

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16498

CERTIFICATE OF DEATH

16497

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in 1b 1 year 1 mom. 23 das.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS Box 198 Rt. 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #30515 First Lola Middle Scott Last Abernathy		4. DATE OF DEATH Month 12 Day 8 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/31/1891
9. AGE (In years lost birthday) yrs. 75		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Scott		14. MOTHER'S MAIDEN NAME Temple <i>Suduth</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to Cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour ----- o.m. ----- p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/15/65 , to 12/8/66 , that (I) (we) last saw the deceased alive on 12/8/66 , and that death occurred at 5:28M , from causes and on the date stated above.			
22a. SIGNATURE <i>Hildegard Heard Reissman</i> M.D.		22b. DATE SIGNED 12/8/66	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12-13-66	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Waterbury, Md.	
24. FUNERAL DIRECTOR <i>Wm. Reel</i> # 108		25a. REC'D BY REGISTRAR DEC 12 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME Charles Judge	

82231

gender : female : age : 26 : gpa : 2.8 : m : 1.7 : height : 5.7 : weight : 130

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14

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16499

16498

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Thelma Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>Thelma Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BLANCHE I. ANGELL</u> First Middle Last			4. DATE OF DEATH <u>DEC 5 1966</u> Month Day Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>7/7/1887</u>		9. AGE (in years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>THOMAS J. Kelley</u>					
14. MOTHER'S MAIDEN NAME <u>MARY Jeffrey</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Donald Angell</u> Address <u>46 Holmehurst Ave #28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-15</u>, 19<u>66</u>, to <u>death</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>12/2</u> 19<u>66</u>, and that death occurred at <u>7 AM</u>, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wayne B. Tate, M.D.</u>				22b. DATE SIGNED <u>12/5/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>WAYNE B. TATE</u>				22d. ADDRESS <u>108 Central Ave Glen Burnie Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEM</u>			
23d. LOCATION (City, town or county) <u>BA/TG. Co.</u>		(State) <u>Md.</u>		24. FUNERAL DIRECTOR <u>E.S. MACNABB</u>			
25a. REC'D BY REGISTRAR DATE <u>DEC 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1032

20431

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16500

CERTIFICATE OF DEATH

16499

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>//////</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		d. STREET ADDRESS <u>202 Glen Road (Glen Gardens)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>N. Arundel Hospital</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First <u>Elsworth</u> Middle <u>Leroy</u> Last <u>Arnold</u>		4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1912</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENR Novelty Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Julia Sank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>213-03-5045</u>	
17. INFORMANT <u>Mrs. Doris M. Arnold (wife)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerosis & Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Employee</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>66</u> , to <u>12/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>66</u> , and that death occurred at <u>1:20 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Philip Bernstein</u>		22b. DATE SIGNED <u>12/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip Bernstein M.D.</u>		22d. ADDRESS <u>112 Chartley Rd. Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 21, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brooklyn RFD Maryland</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 23 1966</u>	

10430

10430

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16507

16500

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>12 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor Nursing Home</u>				d. STREET ADDRESS <u>Oakwood Road (609)</u>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>NMI</u> Last <u>Aversa</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep 28, 1899</u>	
				9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Palermo, Sicily (Italy)</u>	
13. FATHER'S NAME <u>Joseph Aversa</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>6725</u>		17. INFORMANT <u>Joseph F. Aversa</u>	
				Address <u>Town Brook Dr. Baltimore 7, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 305X DUE TO (b) <u>Inanition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Alzheimers Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days (?)</u> <u>2 years</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>26 Feb</u> , 19 <u>66</u> , to <u>11 Dec</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8 Dec</u> , 19 <u>66</u> , and that death occurred at <u>2:01 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Kinzer</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11 Dec 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. KINZER, M.D.</u>				22d. ADDRESS <u>SOUTH RIVER MEDICAL CENTER EDGEWATER, MARYLAND 21037</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>14 Dec. 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

0001

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1

(M)

16502

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16501

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade, Maryland		c. LENGTH OF STAY IN 1b 10 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Maryland		d. STREET ADDRESS 2804 Spangler Main	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodore Middle Anderson Last Baldwin III		4. DATE OF DEATH Month December Day 23 Year 1966	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 June 1900
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months 16 Days 2 Hours 25 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Washington State		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Anderson Baldwin Jr.		14. MOTHER'S MAIDEN NAME Agnes Judge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1925-1945		16. SOCIAL SECURITY NO. 272-14-1114	
17. INFORMANT Jane Baldwin(W)		Address 2804 Spangler Main, Bowie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis, Rt circumflex DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that xx (this hospital) attended the deceased from 2:30AM 23 Dec 19 66 to 18:25 23 Dec 19 66 , that xx (we) last saw the deceased alive on 23 Dec 1966 , and that death occurred at 7:25A M, from causes on and on the date stated above.			
22a. SIGNATURE Carl S. Rosen, M.D.		22b. DATE SIGNED 23 December 66	
22c. PHYSICIAN'S NAME (Type) CARL S. ROSEN, CPT, MC		22d. ADDRESS Kimbrough Army Hospital, Ft Geo G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR JAN 3 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

16501

16502

CERTIFICATE OF DEATH

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

DATE OF REPORT

SIGNATURE OF REGISTRAR

SIGNATURE OF PHYSICIAN

DATE OF REPORT

PLACE OF DEATH

DATE OF REPORT

PLACE OF DEATH

DATE OF REPORT

NAME OF REGISTRAR

DATE OF REPORT

DATE OF REPORT

NAME OF REGISTRAR

DATE OF REPORT

DATE OF REPORT

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NAME OF REGISTRAR

DATE OF REPORT

NAME OF REGISTRAR

DATE OF REPORT

16502

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

80201

4350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Now please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

16504

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #G387 4/7/67 pc

CERTIFICATE OF DEATH

16503

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 mon. 25das.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 1209 E. Oliver	
3. NAME OF DECEASED (Type or print) #33632 John First Middle Last		4. DATE OF DEATH Month 12 Day 4 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890 6/11/1908
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 244-12-1421	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Brain Syndrome sec. Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/21/ , 19 66 , to 12/4/ , 19 66 , that (I) (we) last saw the deceased alive on 12/4/ , 19 66 , and that death occurred on 8:30 M, from causes on and on the date stated above.			
22a. SIGNATURE <i>Hildagard Heard Reissman</i>		22b. DATE SIGNED 12/6/66	
22c. PHYSICIAN'S NAME (Type) Hildagard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-12-66	23c. NAME OF CEMETERY OR CREMATORY Abertus Mem. Pk.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.		25a. REC'D BY REGISTRAR DATE DEC 14 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles R. Law</i>	

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F i n e

Chas. E. Smith, Inc., 809 Jackson Ave.,

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16505

CERTIFICATE OF DEATH

16504

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Grandview Rd</u>		d. STREET ADDRESS <u>Grandview Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>MAE</u> Last <u>BROOKS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-70</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife @ home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>@ home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>md (Preston)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES CRAIG</u>		14. MOTHER'S MAIDEN NAME <u>JULIA COOKE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>James Brooks</u>		Address <u>6 Bruce Rd Poles</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Anemia</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Colon</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1966</u> , to <u>Dec 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 22, 1966</u> , and that death occurred at <u>7:01</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ray Smith</u>		22b. DATE SIGNED <u>Dec 27, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAY SMITH</u>		22d. ADDRESS <u>RITCHIE HWY SEVERNA PK</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/26/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Meth. Ch.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arnold A.A. md</u>
24. FUNERAL DIRECTOR <u>Robert Barranco</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 27 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16506

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
c. LENGTH OF STAY IN 1b 20 days		d. STREET ADDRESS 11 Brice Road, Pendennis Mt.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Rose BURNS		4. DATE OF DEATH December 5 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. BIRTHPLACE (County & State, or foreign country) WALTON Massachusetts	
14. FATHER'S NAME WILLIAM Mc GOWAN		15. MOTHER'S MAIDEN NAME MARY Mc GRATH	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 325-28-5740	
18. INFORMANT MRS. R. A. LYNCH #2		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of head of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Richard I. Hochman attended the deceased from Sept. 23, 1966 to Dec. 5, 1966 that (I) was last saw the deceased alive on Dec. 5, 1966 , and that death occurred at 12:50 PM M, from causes on and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 12/6/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12-8-1966	
23c. NAME OF CEMETERY OR CREMATORY EL CARMELLO CEMETERY LITTLE CHAPEL BY THE SEA		23d. LOCATION (City or Town) (County) (State) PACIFIC GROVE CALIFORNIA	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.		25a. REC'D BY REGISTRAR DATE DEC 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16507

16506

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CROFTON</u> c. LENGTH OF STAY IN 1b <u>MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1646 DRYDEN COURT</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CROFTON</u> d. STREET ADDRESS <u>1646 DRYDEN COURT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> <u>E.</u> <u>CALLAHAN</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>1</u> Year <u>1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Jan 13-1877</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>RED BANK PA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>MICHAEL CALLAHAN</u>		14. MOTHER'S MAIDEN NAME <u>ROSEANN MCCLYNCH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>MRS. REGINALD GERACI #2</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular disease</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Seizure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1966</u> to <u>Dec. 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 1, 1966</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Max C Frank MD</u>		22b. DATE SIGNED <u>12/2/66</u>		22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>			
22d. ADDRESS <u>CROFTON MED. GROUP</u> <u>CROFTON MD 21113</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. CATHERINES CEM.</u>			
23d. LOCATION (City, town or county) (State) <u>Du Bois PENN.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u> ADDRESS <u>SONS ANNAPOLIS MD</u>					
25a. REC'D BY REGISTRAR <u>DEC 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Clark
Michael Campbell
Mrs. Howard Clark

Mr. Howard Clark

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
Duplicate									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Severna Park</u> c. LENGTH OF STAY IN ID <u>Expired in route</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>in ambulance while enroute</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna</u> d. STREET ADDRESS <u>Box 222</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Robin Ann Canter</u>			First Middle Last		4. DATE OF DEATH <u>December 7 19 66</u> Month Day Year				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1966</u>		9. AGE (In years last birthday) <u>1 16 40</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Robert Canter</u>					14. MOTHER'S MAIDEN NAME <u>Patsy Ann Bradshaw</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>A.A. Gen.Hosp. records</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System Hemorrhage</u> 7600 DUE TO <u>Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infection</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 5</u> , 19 <u>66</u> , to <u>Dec. 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7</u> , 19 <u>66</u> , and that death occurred at <u>3:30 AM</u> on the causes and on the date stated above. 22a. SIGNATURE <u>Charles B. Hargrave</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1-5-67</u> 22c. PHYSICIAN'S NAME (Type) <u>C.B. Hargrave</u> 22d. ADDRESS <u>Hahn Bldg. Severna Park, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>December 10, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u> 24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u> <u>Hopping Funeral Home</u> <u>Annapolis, Md.</u> 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE <u>JAN 10 1967</u>									

Film B 384- 1/10/67- MB.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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16509

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16507

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stony Beach c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2022 Fernhill Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A. A. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stony Beach d. STREET ADDRESS 2022 Fernhill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle S. Last Carney		4. DATE OF DEATH Month December Day 6 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1902
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 02 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Diner	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Sayles		14. MOTHER'S MAIDEN NAME Eva Theresa Connors	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. William M. Shanahan		Address 2022 Fernhill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO (b) arteriosclerotic cardiovascular disease DUE TO (c) Anemia			INTERVAL BETWEEN ONSET AND DEATH minutes years undetermined
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 25, 1966 to Dec. 6, 1966 , that (I) (we) last saw the deceased alive on Dec. 2, 1966 , and that death occurred at 12-6-66 from the causes and on the date stated above.			
22a. SIGNATURE Henry Armanas		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HENRY ARMANAS		22d. ADDRESS 1934 Wilkens Ave. Balto 23 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/9/1966	23c. NAME OF CEMETERY OR CREMATORY Louder Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Wm. J. Tuckner & Sons		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DATE DEC 8 1966	

16307

16307

0800-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16510

CERTIFICATE OF DEATH

16508

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSP.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1109 CONDENT ST.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET JOHNS SKINNER CARR</u> First Middle Last		d. STREET ADDRESS <u>ANNAPOLIS</u>	
4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6, 1897</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOUT.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES H. CARR</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA WOOD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>STUART CARR, BRANDYWINE, MD.</u>	
17. INFORMANT <u>STUART CARR, BRANDYWINE, MD.</u>		Address <u>RT 1 BOX 217</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral heart disease</u> (c) <u>Yours.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> , 19 <u>62</u> , to <u>12/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>66</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gerard Cheneit</u>		22b. DATE SIGNED <u>12/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHENEIT</u>		22d. ADDRESS <u>121 CATHCROFT AVE ST ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-22-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST THOMAS Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>CROOM P.G., MD.</u>	
24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WALDORF, MD</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1950

1950

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16513

CERTIFICATE OF DEATH

16509

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 5 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 28 East Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marie Michele Cassavetis				4. DATE OF DEATH Month Day Year December 3 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1897		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) New York ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LIBERATO GAGLIARDI				14. MOTHER'S MAIDEN NAME ISABELLA BARBERI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address 603 GARWOOD AVE MR. ANTHONY PATELIS JR. MT PROSPECT ILL.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Congestive Failure DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) XXXXXX attended the deceased from 12-1-1966 , to Dec 3, 1966 , that (I) (we) last saw the deceased alive on 12-2-1966 , and that death occurred at 2:10 AM from causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-4-66	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY				22d. ADDRESS 121 Cathedral Street, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/6/1966		23c. NAME OF CEMETERY OR CREMATORY U.S. NATIONAL CEM.		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS AA Co. MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.				25a. REC'D BY REGISTRAR DATE DEC 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

18503

WEST COAST DISTRICT

18513

[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16512						16510					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Anne Arundel			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b MARYLAND			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, Annapolis, Md.		
a. STATE Maryland			b. COUNTY Anne Arundel			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis, Md.			d. STREET ADDRESS 95 Franklin Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Isabelle Miller COCHRAN			4. DATE OF DEATH December 14 1966								
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 14, 1891		9. AGE (in years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11b. KIND OF BUSINESS OR INDUSTRY HOME				11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip J. Miller						14. MOTHER'S MAIDEN NAME Virginia Arnot					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. —		17. INFORMANT Schamyl Cochran		Address #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ENDOMETRIUM OF UTERUS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				22d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)			
21. I certify that (i) (this hospital) attended the deceased from <u>28 October, 1966</u> to <u>14 December 1966</u> , that (i) (we) last saw the deceased alive on <u>14 December 1966</u> , and that death occurred at <u>1948</u> M, from the causes and on the date stated above.											
22a. SIGNATURE Barry John Coughlin						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) BARRY JOHN COUGHLIN						22d. ADDRESS U.S. Naval Hospital, Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
CREMATION		12-15-66		Ft. Lincoln		Bladensburg Md.					
24. FUNERAL DIRECTOR John M. Taylor & Sons, Duke of Gloucester St.						25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

16316

16316

Barryland

Barryland

Barryland

Barryland

St. Paul's Street

U.S. Naval Hospital, Annapolis, Md.

December 19

Barryland

Barryland

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Barryland

[Faint, illegible handwritten text]

19 October 1955

19 October

U.S. Naval Hospital, Annapolis, Md.

Barryland

John A. Taylor & Sons, One of Gloucester St.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16513

16511

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Margarets		c. LENGTH OF STAY IN 1b 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bay Manor Nursing Home		d. STREET ADDRESS Rt 4 Box 20	
3. NAME OF DECEASED (Type or print) Edward Collinson		4. DATE OF DEATH Month Dec. Day 5 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 16 Days 10 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired - farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (County & State, or foreign country) Edgewater, A.A.Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Collinson		14. MOTHER'S MAIDEN NAME Mary Elizabeth Brewer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-16-3856	
17. INFORMANT Mrs. Mary M. Collinson-wife same as #2 above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERAL THROMBOSIS DUE TO (b) ARTERIOCLEROSIS, GENERALIZED DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 16 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JUNE , 1961, to 5 DEC , 1966, that (I) (we) last saw the deceased alive on 20 NOV , 1966, and that death occurred at 9A M, from the causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EDWARD S. BECK		22d. ADDRESS 71 FRANKLIN ST, ANNAPOLIS MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/8/66	23c. NAME OF CEMETERY OR CREMATORY All Hallows	23d. LOCATION (City, town or county) (State) Birdsville, A.A. Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Deverley E. Hopping Hopping Funeral Home		25a. REC'D BY REGISTRAR DEC 8 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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11

10513

10511

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16514

CERTIFICATE OF DEATH

16512

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Nursing & Conv. Center</u>		d. STREET ADDRESS <u>P.O. Box 5</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James FRANKLIN Collison</u>		4. DATE OF DEATH Month Day Year <u>December 5, 19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1891</u>
9. AGE (In years lost birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>James B. F. Collison</u>		14. MOTHER'S MAIDEN NAME <u>Ida Gardiner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-28-8915-A</u>	
17. INFORMANT <u>Mrs. Robt. Mitchell, P.O. Box 5, Mayo, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the right lung</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>13 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19, 19 66</u> , to <u>Dec. 5, 19 66</u> that (I) (we) last saw the deceased alive on <u>Dec. 5, 19 66</u> , and that death occurred at <u>2:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Albert L. Anderson</u>		22b. DATE SIGNED <u>12-8-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert L. Anderson, M.D.</u>		22d. ADDRESS <u>44 Southgate Ave., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-8-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOIS, Md</u>	
24. FUNERAL DIRECTOR <u>Hendricky Funeral Home, Annapolis, Md</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>			

S1201

1281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16515 **CERTIFICATE OF DEATH** **16513**

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Governor's Bridge Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville d. STREET ADDRESS Governor's Bridge Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank W. Colona			4. DATE OF DEATH Month December Day 1 Year 1966				
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1899	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 02 Days 1 Hours 00 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer- Retired		10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (County & State, or foreign country) Parksley, Virginia			
13. FATHER'S NAME Edward Colona			14. MOTHER'S MAIDEN NAME Bert White				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1 224-22-4331		17. INFORMANT Mrs. Dorothy T. Colona Address Same as # 2 Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) coronary artery disease @ hypertension DUE TO (c) generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from August , 19 66 , to Dec 1 , 19 66 , that (I) (we) last saw the deceased alive on Dec 1 , 19 66 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Emily H. Wilson				22b. DATE SIGNED 12/1/66			
22c. PHYSICIAN'S NAME (Type) Dr. Emily Wilson		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 3, 1966	23c. NAME OF CEMETERY OR CREMATORY All Hallows Chapel	23d. LOCATION (City, town or county) (State) Davidsonville, A.A. Md.				
24. FUNERAL DIRECTOR Bernley E. Hopping Hopping Funeral Home		ADDRESS 172 West St. Md.	25a. REC'D BY REGISTRAR DEC 5 1966 25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16516

CERTIFICATE OF DEATH

16514

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1121 FOREST DR.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph W. Cook Sr.</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VEG. + FLOWERS</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH A. COOK</u>		14. MOTHER'S MAIDEN NAME <u>LAURA V. PENNSMITZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218143325A</u>	
17. INFORMANT <u>LILLIE M COOK</u>		Address <u># 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u>DUE TO</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>63</u> , to <u>12/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> , 19 <u>66</u> , and that death occurred at <u>8 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman, MD</u>		22b. DATE SIGNED <u>12/7/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, MD</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-9-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Sykes Annapolis Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 9 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12516

CERTIFICATE OF DEATH

12516

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Signature of physician
6. Signature of registrar
7. Date of registration

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16517

CERTIFICATE OF DEATH

16515

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN Ib D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS SEVERN RIDGE Rd			
3. NAME OF DECEASED (Type or print) First Allen Middle BYRON Last CRISP				4. DATE OF DEATH Month December Day 23 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1889	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 23 Days 19		IF UNDER 24 HRS. Hours 19 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REL. PERSONEL				10b. KIND OF BUSINESS OR INDUSTRY USF + G		11. BIRTHPLACE (County & State, or foreign country) A.A. Co, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Wm Crisp				14. MOTHER'S MAIDEN NAME MARY CHARK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Crisp Address elove	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) D.O.A. - probably DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Angina Pectoris INTERVAL BETWEEN ONSET AND DEATH 3 yrs -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 9:55 AM				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from July 1964 to 12-23-1966 , that (I) (the hospital) last saw the deceased alive on 26 Nov 66 and that death occurred at M , from causes and on the date stated above.							
22a. SIGNATURE Frank M Shipley				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-23-66	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/66		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION (City or Town) (County) (State) Glen Burnie Md	
24. FUNERAL DIRECTOR Robert S. Barranco				25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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A. S. G.

Figure 1

1. Introduction

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16512

CERTIFICATE OF DEATH

16516

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Rt-2, Box-15 ST MARGARETS	
3. NAME OF DECEASED (Type or print) Raymond Albert DAWSON		4. DATE OF DEATH Month December Day 1 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1925
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY PETROLEUM CORP.	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALBERT DAWSON		14. MOTHER'S MAIDEN NAME BERTHA WOLFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES 6/4/43-1/6/48		16. SOCIAL SECURITY NO. 233-30-5206	
17. INFORMANT Mrs. PAULINE H. DAWSON #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unrelieved arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June , 19 58 , to Dec , 19 66 , that (I) (we) lost the deceased alive on 15 Nov , 19 66 , and that death occurred at 12:50 A.M. from causes and on the date stated above.			
22a. SIGNATURE John L. Hedeman		22b. DATE SIGNED 12/2/66	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-3-1966	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST MEM. CEM.		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS AACo. MD	
24. FUNERAL DIRECTOR JOHN M. TAYLOR, SON'S ANNAPOLIS MD.		25a. REC'D BY REGISTRAR DEC 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
16519					16517					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY			
Anne Arundel		Annapolis			Maryland		Anne Arundel			
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
		119 Granville Ave.			Annapolis		119 Granville Ave.			
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last					Month Day Year					
Garnard E. Day					Dec. 19 19 66					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 9, 1884		82 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Clerk - ret.				Railroad		Millersville, Md.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Richard T. Day					Sarah Upton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
no		215-07-4743		Mrs. Pearl V. Day-wife same as #2 above						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS										
4201 DUE TO										
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) ARTERIOSCLEROTIC HEART DISEASE										
DUE TO										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 12 MAY, 1959, to 12-19, 1966, that (I) (we) last saw the deceased alive on 12-19, 1966, and that death occurred at 12 M, from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED					
Edward S. Beck					12-20-66					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial		12/22/66		Baldwin Memorial Cemetery		Millersville, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					
Beverley E. Hopping					25b. REGISTRAR'S SIGNATURE					
HOPPING FUNERAL HOME - Annapolis, Md.					DATE DEC 23 1966					

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26-5-51

Edward L. Davis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16520					16518				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Anne Arundel</u>					a. STATE <u>Maryland</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>					b. COUNTY <u>Anne Arundel</u>				
c. LENGTH OF STAY IN 1b <u>21hrs15min</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>					d. STREET ADDRESS <u>Rt. 3 Box 52</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <u>Lorraine Elizabeth Dodson</u>					Month Day Year <u>December 27 1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 26, 1966</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. <u>21 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hobbs Dodson</u>					14. MOTHER'S MAIDEN NAME <u>Lorraine Anina Turner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u>		Address <u>As above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome</u> <u>7625</u> DUE TO <u>Cerebral Anoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>Prematurity</u>								INTERVAL BETWEEN ONSET AND DEATH <u>21 hrs 15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 26</u> , 19 <u>66</u> , to <u>Dec. 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 27</u> 19 <u>66</u> , and that death occurred at <u>5:25 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Sherman Robinson</u>					M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Sherman Robinson</u>					ADDRESS <u>Hahn Building Severna Park, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12:28:66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>			
24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u>		ADDRESS <u>Hopping Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Beverley E. Hopping</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 28 1966</u>	

16518

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16519

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "George" and "John" are faintly visible.]

[Faint text at the bottom of the page, possibly a signature or date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 439 Patuxent Road	
3. NAME OF DECEASED (Type or print) First Wylie Middle Lee Last DONALDSON		4. DATE OF DEATH Month December Day 28 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1885
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months 02 Days 21 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Master(ret)		10b. KIND OF BUSINESS OR INDUSTRY U.S. CIVIL SERVICE	
11. BIRTHPLACE (County & State, or foreign country) Waugh Chapel Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Caleb F. Donaldson		14. MOTHER'S MAIDEN NAME Nannie Mewburn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-34-9249A	
17. INFORMANT Wylie L. Donaldson - Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Uremia DUE TO (b) Carcinoma Prostate Gland DUE TO (c) 18 mos		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) the doctor attended the deceased from Dec. 28, 1966 to Dec. 28, 1966 that (1) we last saw the deceased alive on Dec. 28, 1966 , and that death occurred at 5:30 AM M, from causes and on the date stated above.			
22a. SIGNATURE Theodore G. Osius, Jr. M.D.		22b. DATE SIGNED 12/ 28/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 77 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/66	
23c. NAME OF CEMETERY OR CREMATORY Epiphany Church Cemetery		23d. LOCATION (City or Town) (County) (State) Odenton, Maryland	
24. FUNERAL DIRECTOR Robert P. Ware		25a. REC'D BY REGISTRAR J. Charles Judge	
25b. REGISTRAR'S SIGNATURE Singleton Funeral Home/Glen Burnie, Md.		DATE JAN 3 1967	

16518

13253

STATE OF TEXAS

County of _____

City of _____

State of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16522 CERTIFICATE OF DEATH 16520

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Orande Ger'l. Hosp -</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>#7857 - Balto./Annap. Blvd -</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>B.</u> Middle <u>Donoho</u> Last		4. DATE OF DEATH <u>12</u> / <u>26</u> / <u>66</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md. -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Worthington</u>		14. MOTHER'S MAIDEN NAME <u>Carrie B. Ogle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. George Donohoe</u> Address <u>Same As #4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> 331X DUE TO (b) <u>Acute pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Cerebrovascular accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus with acidosis, Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19</u> , 19 <u>66</u> , to <u>Dec 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 26</u> 19 <u>66</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Max C Frank</u>		22b. DATE SIGNED <u>12/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK M.D.</u>		22d. ADDRESS <u>425 SE Ritchie Hwy Glen Burnie Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 29/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balto., Md. -</u>	
24. FUNERAL DIRECTOR <u>R. K. Dingle</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10250

10250

George H. Jones Jr. (2nd fl.)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items 18&21 Film 385 2-3-67 MARYLAND STATE DEPARTMENT OF HEALTH
3 & 18 Film 385 2-14-67 ams
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16521

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pumphrey Farm North Arundel General				d. STREET ADDRESS Pumphrey Farm			
3. NAME OF DECEASED (Type or print) First Middle Last Roger Rodger Duckett Duckett				4. DATE OF DEATH Month Day Year 12 24 19 66			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1921	
9. AGE (In years last birthday) yrs. 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		11. BIRTHPLACE (State or foreign country) Brandwine, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wilbert Brown				14. MOTHER'S MAIDEN NAME Luvencia Duckett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 215-20-8325		17. INFORMANT Luvencia Duckett Address 830 E. 22nd St. Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholic intoxication associated DUE TO (b) possibly associated with exposure CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				22. DATE SIGNED 12/25/66			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-30-'66		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Martell Adams Aguas, Md.				25a. REC'D BY REGISTRAR DATE JAN 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1881

1881



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16524

CERTIFICATE OF DEATH

16522

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 413 Cummings Ct.			
3. NAME OF DECEASED (Type or print) #34085 Heulitt Dunston				4. DATE OF DEATH Month 12 Day 22 Year 19 66			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> sep. DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/98	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ed Dunston				14. MOTHER'S MAIDEN NAME Crews			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-03-5518		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral DUE TO (b) Uremia DUE TO (c) Hypertensive Cardio-Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis Diabetes, Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year How on 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 12/15/ , 19 66 , to 12/22/ , 19 66 that (I) (we) last saw the deceased alive on 12/22/19 66 , and that death occurred at 11:20 , from causes and on the date stated above.							
22a. SIGNATURE L. Benedict				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/22/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City or Town) (County) (State) H.A.C. Md.	
24. FUNERAL DIRECTOR Aslington S. Phillips				ADDRESS 1727 N. Mount		25a. REC'D BY REGISTRAR DATE DEC 28 1966	
						25b. REGISTRAR'S SIGNATURE f. Charles Judge	

VR A15 (4)
20 M 1/66

1025

SSG 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13

16525

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16525

1. PLACE OF DEATH a. COUNTY AA Co MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burhie c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Gen. Hosp				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) Ma STATE AA Co c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ferndale d. STREET ADDRESS 11 Cromwell St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Bertha M Feldpusch		4. DATE OF DEATH Dec 14 19 66		5. SEX Female		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1879		9. AGE (In years last birthday) 87 yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Unk				14. MOTHER'S MAIDEN NAME Unk				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No													
16. SOCIAL SECURITY NO.				17. INFORMANT Family				Address Same													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Arteriosclerotic heart disease (c) Emphysema with bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from June 26, 1962, to Dec. 14, 1966, that (I) (we) last saw the deceased alive on Dec. 12, 1966, and the death occurred at 3:00 AM, from the causes and on the date stated above.																					
22a. SIGNATURE Edmond I. Moushabeck M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED													
22c. PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABECK				22d. ADDRESS 510 Harley station Road, Glen Haven, Md 21061																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/16/66		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION (City, town or county) AA Co Ma													
24. FUNERAL DIRECTOR'S SIGNATURE McCully F H				ADDRESS 237 Patapsco Ave 21225		25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge													

5501

ST/2000/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16526

Item 7 Film G384 12/29/66 mh

CERTIFICATE OF DEATH

16526

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 208 Lockwood Court			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Robert Middle Kent Last FORD				4. DATE OF DEATH Month December Day 22 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 21, 1926		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 22 Days 19	IF UNDER 24 HRS. Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY ARMED FORCES		11. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ROBERT T. FORD				14. MOTHER'S MAIDEN NAME AMY R. AMOS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (no, or unknown) (If yes give war or dates of service) YES WWII KOREA		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. AMY R. FORD (MOTHER) #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) Rheumatic heart disease							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Port. op. subdural hemaloma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (deceased) attended the deceased from 19 , to 19 , that (I) (deceased) last saw the deceased alive on 19 , and that death occurred at 3:35 PM , from causes and on the date stated above.							
22a. SIGNATURE Ray M. Smith				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/23/1966	
22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.				22d. ADDRESS Hahn Prof Bldg., Severna Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/24/1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SOWS ANNAPOLIS MD.				25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Address:

1998

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2000

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16527

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HACO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY HACO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Bernie		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Don-North. AKUNDIEL		e. STREET ADDRESS 5418 Rugby Road	
3. NAME OF DECEASED (Type or print) Archie James Fox		4. DATE OF DEATH Month 12 Day 17 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HORSEMAN		10b. KIND OF BUSINESS OR INDUSTRY SHOE MFG.	9. AGE (In years last birthday) yrs. 77
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES FOX		14. MOTHER'S MAIDEN NAME CHARLOTTE WILSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-01-0187	
17. INFORMANT INEZ MASTERS 5418 Rugby Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aluminum jumper DUE TO (b) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhart		22. DATE SIGNED 12/17/66	
EXAMINER'S NAME (Type) E. Linhart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-20-66	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	23d. LOCATION (City or Town) (County) (State) BALTIMORE MD
24. FUNERAL DIRECTOR'S NAME (Type) Francis H. Miller		25a. REC'D BY REGISTRAR DEC 21 1966	
25b. REGISTRAR'S SIGNATURE Francis H. Miller		26. REGISTRAR'S SIGNATURE Francis H. Miller	

10252

10252

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16528

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16528

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton Fort Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital		d. STREET ADDRESS 495 Barbara Lane	
3. NAME OF DECEASED (Type or print) First Leo Middle F. Last GAFFNEY		4. DATE OF DEATH Month December Day 18 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1921
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 45 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Colonel - ret.		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Dedham, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo V. Gaffney		14. MOTHER'S MARDEN NAME Marion Gallagher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1942-1966		16. SOCIAL SECURITY NO. 014-16-1529	
17. INFORMANT Mrs. Betty Lou Gaffney-wife same as #2 above		18. ADDRESS same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 8124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Pedestrian struck by auto		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 9:58 p.m. 12-18 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Odenton A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED December 19, 1966	
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Ft. Myer Va.	
24. FUNERAL DIRECTOR'S NAME Beverly E. Hopping Hopping Funeral Home		25a. REC'D BY REGISTRAR DEC 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

16529

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16529

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS Box 439, Waugh Chapel Road	
3. NAME OF DECEASED (Type or print) EDWARD GALLOWAY		4. DATE OF DEATH pronounced December 2, 1966	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 6-1922
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
11. BIRTHPLACE (State or foreign country) Odenton MD		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Oliver Galloway		14. MOTHER'S MAIDEN NAME Georgiana Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or date of service) WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT HEAVOR GALLOWAY		Address Box 439 Odenton MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 830.4 IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Compression of thorax DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pinned under car when jack slipped	
20c. TIME OF INJURY 12-1 or 12-2 Month, Day, Year Hour a.m. p.m. 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Anne Arundel (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED 12-3-66	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/1966	
23c. NAME OF CEMETERY OR CREMATORY BALTON NATIONAL		23d. LOCATION (City or Town) BALTO MD (County) (State)	
24. FUNERAL DIRECTOR Marlene P. Hayes		25a. REC'D BY REGISTRAR DEC 5 1966	
ADDRESS 638 N. Green St		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Nov 1952
O'Brien RD WA
Deere and Tuck
Electric Co. for 1952

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O'Brien RD WA
Deere and Tuck
Electric Co. for 1952

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O'Brien RD WA
Deere and Tuck
Electric Co. for 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16530

16530

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL ANNA. MD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS d. STREET ADDRESS 1012 FOREST HILL ANNA. MD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) PHILIP NELSON		First PHILIP NELSON		Middle GIRARD JR.		Last GIRARD JR.		4. DATE OF DEATH DEC. 27 1966	
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 25, 1966		9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR Months 2 Days 2 IF UNDER 24 HRS. Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME PHILIP NELSON GIRARD				14. MOTHER'S MAIDEN NAME CAROL ANN BELL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 25 DEC 1966 to 27 DEC 1966 , that (I) (we) last saw the deceased alive on 27 DEC 1966 , and that death occurred at 4:45P from the causes and on the date stated above.									
22a. SIGNATURE James A. Murray M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-27-66			
22c. PHYSICIAN'S NAME (Type) J. A. MURRAY, LT MC USN				22d. ADDRESS USNH ANNAPOLIS, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-29-66		23c. NAME OF CEMETERY OR CREMATORY U.S.N.A.		23d. LOCATION (City, town or county) ANNAPOLIS		(State) MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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ANNAPOLIS

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1011 WEST HILL AVE., MD.

NAVAL HOSPITAL ANN. MD.

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UNITED STATES

ARMY HOSPITAL, MARYLAND

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U. S. NAVY, LT. JG. USN

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

16531

16531

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
c. LENGTH OF STAY IN 1b <u>8 Years</u>				d. STREET ADDRESS <u>180 Solley Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>180 Solley Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ambrose Griffith</u>				4. DATE OF DEATH <u>December 29, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15, 1890</u>	
9. AGE (In years last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman - Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wilmington, Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Frank Griffith</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Ortmann</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Mrs. Ruth Upton, same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>260X</u> DUE TO (b) <u>Coronary Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>2 years</u> <u>10 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1/66</u> to <u>12/29/66</u> , that (I) (we) last saw the deceased alive on <u>12/15/66</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R.M. McLaughlin</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Randall McLaughlin, M.D.</u>				22d. ADDRESS <u>3708 Mountain Road, Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md. 21225</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kirkley Funeral Home, Glen Burnie, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JAN 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10531

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16532

CERTIFICATE OF DEATH

16532

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 32 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 80 Franklin Street	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Joseph HARDESTY		4. DATE OF DEATH Month Day Year December 15 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1902
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days 15 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen Utilities		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) A.A. Co Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Hardesty		14. MOTHER'S MAIDEN NAME Mary Ann Swann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. 212-52-4508	
17. INFORMANT Lula C. Hardesty		Address Annapolis, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 334X DUE TO (b) arteriosclerotic Cerebral Vascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-9-66 , 19__, to 12-15-66 , 19__, that (I) (we) last saw the deceased alive on 12-15-66 , 19__, and that death occurred at 1:45 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE Per T. Allen		22b. DATE SIGNED 12-16-66	
22c. PHYSICIAN'S NAME (Type) A T ALLEN		22d. ADDRESS 62 Gethers St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/19-66	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or Town) (County) (State) Annapolis A.A.Co Md
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md		25a. REC'D BY REGISTRAR DATE DEC 21 1966	
		25b. REGISTRAR'S SIGNATURE James Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 02.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Thompson Street				d. STREET ADDRESS 2 Thompson Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DOROTHY Middle M. Last HEFFORD				4. DATE OF DEATH Month December Day 15 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-27-1903	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 15 Hours 19 Min.		IF UNDER 24 HRS. Months 63 Days 15 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME				10b. KIND OF BUSINESS OR INDUSTRY WIFE		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? ENGLISH				13. FATHER'S NAME UNK			
14. MOTHER'S MAIDEN NAME UNK				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. ---				17. INFORMANT WMA. FRANCH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 980X IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) barbiturates. DUE TO (c) Plastic bag wrapped about head following ingestion of/				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Barbiturate Intoxication.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) barbiturates.		20c. TIME OF INJURY Month, Day, Year 12/ 13 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis Anne Arundel Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 12/15/66	
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) 212 BRUCESTER ST. ANNAPOLIS, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 12-23-66	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) SHADENSBURG MD.		24. FUNERAL DIRECTOR John M. Lyons		25. RECEIVED BY REGISTRAR DEC 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		26. ADDRESS 212 BRUCESTER ST. ANNAPOLIS, MD.		27. DATE DEC 21 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16534

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16534

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Thompson Street				d. STREET ADDRESS 2 Thompson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAURICE Middle R Last HEFFORD				4. DATE OF DEATH Month December Day 15 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1914		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DESIGN ENGINEER			10b. KIND OF BUSINESS OR INDUSTRY ENGINEER		11. BIRTHPLACE (State or foreign country) Peterborough England		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN L. HEFFORD				14. MOTHER'S MAIDEN NAME AIMEE REMONDI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO. 098-32-4405		17. INFORMANT W. H. FRANCH 212 G. L. Address E. ST. ANNAPOLIS, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9702 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Barbiturate Intoxication.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overdose of barbiturate and enclosed self in mattress cover				
20c. TIME OF INJURY Month, Day, Year Hour 8:00 p.m. 12/13 19 66			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE @ Charles S. Petty			M.D.		22. DATE SIGNED 12/15/66		
EXAMINER'S NAME (Type) Charles S. Petty			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 12-23-66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Bladensburg MD.	
24. FUNERAL DIRECTOR John M. Loggins & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1934

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16535

CERTIFICATE OF DEATH

16535

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Manor Nursing Home		d. STREET ADDRESS 116 Point Pleasant Rd.	
3. NAME OF DECEASED (Type or print) First Amelia Middle M. Last Heinzerling		4. DATE OF DEATH Month December Day 14 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1879
9. AGE (In years) 87 (birthday) yrs.		10. IF UNDER 1 YEAR Months 10 Days 14 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linen Room		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Heinzerling		14. MOTHER'S MAIDEN NAME Louise Schlemmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-32-5079	
17. INFORMANT Mrs. Grace L. Blohm		Address 323 Stevenson Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Convulsion DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral anoxia DUE TO (c) Arteriosclerosis generalized			INTERVAL BETWEEN ONSET AND DEATH 10 min year year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Angerive heart failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 12, 1966 to Dec 14, 1966 , that (I) (we) last saw the deceased alive on Dec 13, 1966 , and that death occurred at 9:50 M, from causes and on the date stated above.			
22a. SIGNATURE David Abramson		22b. DATE SIGNED 12/14/66	
22c. PHYSICIAN'S NAME (Type) David Abramson		22d. ADDRESS 702 Balto - Annap. Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/19/66	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE DEC 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16536

CERTIFICATE OF DEATH

16536

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 5 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		021	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNAPOLIS NURSING & CONV. CENTER		d. STREET ADDRESS 201 MELVIN AVE.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle C. Last HEISE		4. DATE OF DEATH Month DEC. Day 16 Year 1966	
5. SEX M	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 28, 1873
9. AGE (In years last birthday) yrs. 93		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVT.	
11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL Co., MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALEXANDER HEISE		14. MOTHER'S MAIDEN NAME ANGUSTA ROEDIGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT RICHARD E. HEISE		Address 15 DEAN ST., ANNAPOLIS, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prostate carcinoma 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 63 , to 12/16 , 19 66 , that (I) (we) last saw the deceased alive on 12/14 , 19 66 , and that death occurred at 11:58 AM , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 12/16/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, MD		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-19-1966	
23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD	
24. FUNERAL DIRECTOR John M. Taylor, San Annapolis Md		25a. REC'D BY REGISTRAR DATE DEC 20 1966	
25b. REGISTRAR'S SIGNATURE James Judge			

16236

CERTIFICATE OF DEATH

16236

Blank form with horizontal lines for text entry.

11-10-1903

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16537

CERTIFICATE OF DEATH

16537

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b <u>SHADY SIDE MARYLAND</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHADY SIDE MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>				d. STREET ADDRESS <u>VAN BUREN & BAY RIDGE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY F. HITNER</u>		First Middle Last		4. DATE OF DEATH <u>12 30 1966</u>		Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-1877</u>		9. AGE (In years lost birthday) yrs. <u>89</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRIC ENG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FAYETTEVILLE, KY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN K HITNER</u>				14. MOTHER'S MAIDEN NAME <u>PHOEBE BRODRICK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>209-01-3787</u>		17. INFORMANT <u>ANNAPOLIS NURSING HOME</u> Address <u>VAN BUREN & BAY RIDGE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cor. Cerebral Thrombosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October, 1966</u> to <u>Dec</u> , 1966, that (I) (we) last saw the deceased alive on <u>12/30</u> 1966, and that death occurred at <u>9:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Martin T. Kim</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN T. KIM</u>				22d. ADDRESS <u>SHADY SIDE MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON Va.</u>	
24. FUNERAL DIRECTOR <u>John M. Layla & Sons Annapolis, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10581

CERTIFICATE OF DEATH

10581

THE STATE OF TEXAS, COUNTY OF DALLAS, DECEASED, the undersigned, J. M. [illegible], a duly qualified physician, do hereby certify that [illegible] was born [illegible] at [illegible] Texas, and died [illegible] at [illegible] Texas, of [illegible] at the age of [illegible] years, [illegible] days, and [illegible] hours, the cause of death being [illegible].

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16538

16539

Items 3, 11, 13, 17 Film G383 12/19/66 mh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE d. STREET ADDRESS 718 COTTER ROAD			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE c. LENGTH OF STAY IN b 5 DAYS				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL			
3. NAME OF DECEASED (Type or print) LEONARD FORREST HUMPHRIES				4. DATE OF DEATH Month DECEMBER Day 9 Year 1966			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 April 1900	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd serviceman				10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (County & State, or foreign country) Petersburg, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Lewis Humphries			
14. MOTHER'S MAIDEN NAME Alice (last name unknown)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. 213-28-1586				17. INFORMANT Mrs. Millicent Humphries (wife) Address same as item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIC ARREST DUE TO (b) Ruptured Thoracic Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from 4 Dec 19 66 to 9 Dec 19 66 , that 23 (we) last saw the deceased alive on 9 Dec 19 66 , and that death occurred at 5:55 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Jerold W. Shagrin M.D.				22b. DATE 9 December 1966			
22c. PHYSICIAN'S NAME (Type) JEROLD W. SHAGRIN, CPT, MC				22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/66		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Allen ADDRESS Singleton Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR DEC 14 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16539 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN ID hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 3 Pleasant Court	
3. NAME OF DECEASED (Type or print) MARY ELIZABETH DUCKETT HUNT		4. DATE OF DEATH December 23 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIAGE <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Mar. 7, 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) A.A.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Duckett		14. MOTHER'S MAIDEN NAME Elizabeth Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-2525	
17. INFORMANT James Hunt-3 Pleasant Court Annapolis, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E.G. Linhardt		22. DATE SIGNED 12/23/66	
EXAMINER'S NAME (Type) E.G. Linhardt		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 27-66	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Maryland		25a. REC'D BY REGISTRAR DEC 27 1966 DATE	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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Handwritten notes and stamps, including "RECEIVED" and "FEB 1941".

Handwritten signature

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16540

CERTIFICATE OF DEATH

16541

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> 021	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				d. STREET ADDRESS <u>P.O. Box 700</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wallace W. Irons</u>				4. DATE OF DEATH Month Day Year <u>12- 15 19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-89</u>		9. AGE (In years last birthday) yrs. <u>77</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Electric Lineman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Point Pleasant, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Irons</u>				14. MOTHER'S MAIDEN NAME <u>Luara Fleming</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>153-03-1469</u>		17. INFORMANT Address <u>Laura MacDonald - Same as # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0 Uremia</u> DUE TO (b) <u>Pyelonephritis, Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis; Gastric ulcer; Arteriosclerotic cardiovascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19</u> , 19 <u>66</u> , to <u>Dec. 14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15</u> , 19 <u>66</u> , and that death occurred at <u>4:25 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ernesto A. Tolentino, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Dec 15, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ernesto A. Tolentino, M.D.</u>				22d. ADDRESS <u>Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Catherine's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Seagirt New Jersey</u>	
24. FUNERAL DIRECTOR <u>R.V. Singleton</u>				25a. REC'D BY REGISTRAR <u>DEC 19 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16542

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		d. STREET ADDRESS RT. #2 BOX 83 MARLEY CREEK OR	
3. NAME OF DECEASED (Type or print) WILHELMINA		4. DATE OF DEATH DECEMBER 9 1966	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 2, 1892	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE SMITH		14. MOTHER'S MAIDEN NAME EMMA ELERT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217/01/37950	
17. INFORMANT EMMA V. THALBERG		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Acute Coronary Heart Failure DUE TO (b) ASHD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1966 to Dec 3, 1966, that (I) (we) last saw the deceased alive on Dec 3, 1966, and that death occurred at 12:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. B. J. M.		22b. DATE SIGNED 12/9/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 13, 1966	
23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM'L PARK		23d. LOCATION (City or Town) (County) (State) GLEN BURNIE, MO.	
24. FUNERAL DIRECTOR R.V. SINGLETON		25a. REC'D BY REGISTRAR DATE DEC 14 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10248

10248

Date of birth 1920

(Mr. [illegible])

FOR STATE
HEALTH DEPT.

16542

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16543

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Severn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS Box 52, Disney Road	
3. NAME OF DECEASED (Type or print) BERNOD XXXXXXXX BERNARD JACKSON		4. DATE OF DEATH December 29 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1935
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months 1 Days 29 Hours 19 Min. 66	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		12. BIRTHPLACE (State or foreign country) Odenton, Maryland	
13. FATHER'S NAME Lemuel Jackson		14. MOTHER'S MAIDEN NAME Mabel Haines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-34-1406	
17. INFORMANT Thelma Smith		Address 305 Phelps Ave. Glen Burnie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra and Retroperitoneal infection DUE TO (c) Rupture of duodenum			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of auto into fixed object			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto into fixed object	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12/ 21 19 66 p.m. 3:30		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Odenton Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 12/30/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/67	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR Robert P. Singleton ADDRESS Singleton Funeral Home Glen Burnie, Md.		25. REC'D BY REGISTRAR DATE JAN 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10248

10248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

16543

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16544

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b MAYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Anne Arundel				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				d. STREET ADDRESS Church Circle, Maryland Inn				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Charles Day JACKSON				4. DATE OF DEATH December 19 1966				5. SEX Male				6. COLOR OR RACE Cauc				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12 June 1884				9. AGE (In years last birthday) 82 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.				11. IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief-Musician ret				10b. KIND OF BUSINESS OR INDUSTRY US Navy				11. BIRTHPLACE (County & State, or foreign country) unknown				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles Jackson				14. MOTHER'S MAIDEN NAME Margaret Day				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. none				17. INFORMANT Mrs. Anna G. Day-adm. West Roxbury, Mass.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 1550 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC OBSTRUCTIVE PULM EMPHYSEMA DUE TO (c) HEPATOMA OF LIVER				INTERVAL BETWEEN ONSET AND DEATH				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1 Sept. 1966, to 19 Dec. 1966, that (I) (we) last saw the deceased alive on 19 Dec. 1966, and that death occurred at 1235A M, from the causes and on the date stated above.				22a. SIGNATURE Barry John Coughlin				22b. DATE SIGNED 12-19-66				22c. PHYSICIAN'S NAME (Type) LT BARRY JOHN COUGHLIN, MC USNR				22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/21/66				23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION (City, town or county) (State) Annapolis, Md.							
24. FUNERAL DIRECTOR Beverly E. Hopping				25a. REC'D BY REGISTRAR DATE DEC 22 1966				25b. REGISTRAR'S SIGNATURE Charles Judge				25c. Hopping Funeral Home - Annapolis, Md.																											

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 1515 (5)
6M 1/66

FOR STATE
HEALTH DEPT.

16544

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16545

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rockbridge Road		d. STREET ADDRESS Pronounced	
3. NAME OF DECEASED (Type or print) First HOWARD Middle H. Last JACKSON		4. DATE OF DEATH Month December Day 8 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty metamorphosis of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epilepsy DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fatty metamorphosis of liver.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED December 9, 1966	
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE THEREOF 12-20-66	
23c. NAME OF CEMETERY OR CREMATORY St. Vincent's Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE DEC 22 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
16545		16546	
1. PLACE OF DEATH a. COUNTY XXXXXX Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	c. LENGTH OF STAY IN 1b 1 mo	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn 02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hosp.		d. STREET ADDRESS Rt. 2 Box 150	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS SELBY JEFFREY		4. DATE OF DEATH Month Day Year DECEMBER 9 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Jan. 1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
11. BIRTHPLACE (County & State, or foreign country) A.A. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enos Jeffrey		14. MOTHER'S MAIDEN NAME Clara H. Hood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-36-5590	
17. INFORMANT Emory Downs, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Carcinoid of Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 months</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 30, 1966</u> , to <u>December 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>December 9, 1966</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>E. Roderick Shipley</u>		22b. DATE SIGNED <u>December 10, 1966</u>	
22c. PHYSICIAN'S NAME (Type) E. Roderick Shipley		22d. ADDRESS <u>519 Camp Meade Rd. Luthian</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/66	
23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION (City or Town) (County) (State) A.A. Co. Maryland	
24. FUNERAL DIRECTOR <u>Robert A. Kline</u>		25. REC'D BY REGISTRAR DATE DEC 14 1966	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6260

摘要: 本文探讨了在社会主义市场经济条件下, 如何正确处理国家、集体、个人三者利益关系的问题。文章指出, 国家利益是集体利益和个人利益的基础, 集体利益是个人利益的保障, 个人利益是集体利益的体现。在处理三者利益关系时, 必须坚持国家利益至上, 集体利益次之, 个人利益最后。同时, 也要兼顾个人利益, 充分调动个人的积极性和创造性, 实现国家、集体、个人利益的统一。

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16547

1. PLACE OF DEATH o. COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS Box 1460, Route 1	
3. NAME OF DECEASED (Type or print) First GEORGE Middle Robert Last JENKINS, Jr.		4. DATE OF DEATH Month 12 Day 20 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1933
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 12 Days 20 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George R. Jenkins Sr.		14. MOTHER'S MAIDEN NAME Lillian M. Tippet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-9176	
17. INFORMANT Mrs. George R. Jenkins, Rt. 1, Box 279		Address Charlotte Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injury of Chest 816.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-auto Accident Deceased was Driver	
20c. TIME OF INJURY Month, Day, Year Hour 10:50 p.m. 12 20 1966		20d. INJURY OCCURRED <input checked="" type="radio"/> While at work <input type="radio"/> Not While at work <input type="radio"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.		22. DATE SIGNED 12/21/66	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 23, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Newport, Charles Co., Md.
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR DEC 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16547

16548

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>02.1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1933 West St.</u> e. STREET ADDRESS <u>1933 West St.</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>1933 West St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Edith Johnson</u> First Middle Last		4. DATE OF DEATH <u>12-28-1966</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-1892</u> Yrs.		9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Spriggs</u>		14. MOTHER'S MAIDEN NAME <u>Frances Carpenter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Adora Brandon</u>		17. INFORMANT <u>Adora Brandon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>November 19, 1964</u> to <u>Dec. 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28, 1966</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>R. L. Richardson</u> 22c. PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>110 Clay St., Annapolis, Md., 21401</u>		22b. DATE SIGNED <u>12-28-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u>		25a. REC'D BY REGISTRAR <u>DEC 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

MEDICAL CERTIFICATION

10554

10554

STATE OF TEXAS

1 year

Carroll County of the State of Texas

x

November 18, 1905

Dec. 28

Dec. 30

10-26-05

x

110 City St., Amarillo, W. T.

W. T. ...

DEC 1 1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16548 1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>1 Year</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hosp.</u>		16549 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>407 Old Stage Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Flossie</u> Middle <u>A.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>19 66</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1898</u> 9. AGE (in years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Christopher Ebenhack</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address: <u>Glen Burnie, Md.</u> <u>Mrs. John E. Osterman 407 Old Stage Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diaphile</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>11-14-64</u> 19 <u> </u> , to <u>12-26</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-24-66</u> 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Harry S. Gimbel</u> 22c. PHYSICIAN'S NAME (Type) <u>HARRY S. GIMBEL</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7605 Edmund Ave</u> 22b. DATE SIGNED <u>12-28-66</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec. 29, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u> 24. FUNERAL DIRECTOR <u>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>DEC 30 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16549

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16550

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Gambrills			c. LENGTH OF STAY IN lb Gambrills		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Kimbrough Hospital, Ft. Meade, Md.			d. STREET ADDRESS Box 648		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frances Ruth Jones			4. DATE OF DEATH Month Dec. Day 15 Year 19 66		
5. SEX female	6. COLOR OR RACE caus.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 23, 1917	9. AGE (In years lost birthday) yrs. 49	IF UNDER 1 YEAR Months 49 Days 15 Hours 19 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio	
13. FATHER'S NAME John Carlton		14. MOTHER'S MAIDEN NAME Nellie Emery			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-10-1054		17. INFORMANT Rudy Jones-husband same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Disease DUE TO 434.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 12/15/66
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE E. Linhardt EXAMINER'S NAME (Type)		M.D. E. Linhardt		22. DATE SIGNED 12/15/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 19, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	
23d. LOCATION (City or Town) Ft. Myer		23e. (County) Va.		23f. (State) Va.	
24. FUNERAL DIRECTOR Beverley L. Hopping HOPPING FUNERAL HOME		ADDRESS Beverley L. Hopping Annapolis, Md.		25a. REC'D BY REGISTRAR DATE DEC 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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Robert L. ...

Robert L. ...

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16550

CERTIFICATE OF DEATH

16551

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodland Beach		c. LENGTH OF STAY IN Tb 10 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		d. STREET ADDRESS 4616 Blackwood Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRED First H. Middle JONES Last		4. DATE OF DEATH Month December Day 9 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, if not working, give retired) Retired Molder		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milford Jones		14. MOTHER'S MAIDEN NAME Clentoni Fulton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577 36 5050	
17. INFORMANT Thomas E. Jones Sr. Same as #2 (son)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 63 , to 14 Oct , 19 66 , that (I) (we) lost saw the deceased alive on 14 Oct , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Thomas M. Hutchins		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas M Hutchins		22d. ADDRESS 7315 Landoner Rd. Hyattsville, Md	
23a. BURIAL CREMATION, (Specify) BURIAL		23b. DATE THEREOF 10/12/66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16552

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital				e. STREET ADDRESS Box 31			
3. NAME OF DECEASED (Type or print) LILLIAN JONES				4. DATE OF DEATH Month 12 Day 9 Year 19 66			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1923	9. AGE (In years lost, birthday) 43 yrs.	IF UNDER 1 YEAR Months 43 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer			10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Wells				14. MOTHER'S MAIDEN NAME Anna Nelson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 212-20-8222		17. INFORMANT Mrs. Elsie Collins Address 4023 Cedardale Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Neck DUE TO 812.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Ethylism							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-Pedestrian Accident - Dec. Was Ped.				
20c. TIME OF INJURY Month, Day, Year 7:30 Hour 12 Day 9 Year 19 66			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		
			20f. (City or town) (County) (State) Earleigh Heights Anne Arundel				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 12/10/66	
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-14-66		23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 Laurens St.			ADDRESS		25a. REC'D BY REGISTRAR DEC 12 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

10225

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16552 CERTIFICATE OF DEATH 16553

1. PLACE OF DEATH a. COUNTY AA		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD		b. COUNTY A A Co		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 1818 Norfolk Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Stella		First		Middle		Last Jones		4. DATE OF DEATH Dec		Month		Day 5		Year 1966			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1921		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mass				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frank J Szczecinski						14. MOTHER'S MAIDEN NAME Julia											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Family				Address Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebellar Brain Tumor DUE TO (c) Myocardial Ischemic														INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 10 , 1963, to 12/5/66 , that (I) (we) last saw the deceased alive on 12/4/66 19, and that death occurred at 7:30 P M, from the causes and on the date stated above.																	
22a. SIGNATURE A. R. Sosnowski										M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/7/66	
22c. PHYSICIAN'S NAME (Type) A. R. Sosnowski										22d. ADDRESS 4016 Ritchie Hwy							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/9/66		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem				23d. LOCATION (City, town or county) A A Co Md		(State)					
24. FUNERAL DIRECTOR McGully F H										ADDRESS 237 Patapsco Ave 21225		25a. REC'D BY REGISTRAR DEC 13 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G 383 12/16/66

CERTIFICATE OF DEATH

16554

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS Glen Burnie, Md.	
3. NAME OF DECEASED (Type or print) First Vella Middle B. Last Jones		4. DATE OF DEATH Month 12 Day 9 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-09
9. AGE (In years) 57 yrs.		10. IF UNDER 1 YEAR Months 12 Days 9 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Cejner		14. MOTHER'S MAIDEN NAME Corra Spencer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Matel Cooper		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Corneal failure DUE TO 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertension, Rt Kidney (c) Pulmonary & skeletal metastasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 66 , to 12/9 , 19 66 , that (I) (we) lost saw the deceased alive on 12/9 , 19 66 , and that death occurred at 4:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Guillermo L. Jimenez		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-12-66	23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cert	23d. LOCATION (City or Town) (County) (State) Brooklyn Md
24. FUNERAL DIRECTOR Elroy O. Wilson, Baltimore Md.		25a. REC'D BY REGISTRAR DATE DEC 12 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

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DEPARTMENT OF THE ARMY

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OFFICE OF THE
ADJUTANT GENERAL
WASHINGTON, D.C.
JAN 10 1917

16554

CERTIFICATE OF DEATH

16555

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital			d. STREET ADDRESS Arnold		
3. NAME OF DECEASED (Type or print) First Middle Last Rachel Lucretia JUSTICE			4. DATE OF DEATH Month Day Year December 22 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 5, 1886		9. AGE (In years last birthday) yrs. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Charles Dulin			14. MOTHER'S MAIDEN NAME Arreh V. Kirby		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) this hospital attended the deceased from JUNE 15, 1965 , to Dec. 21, 19 66 , that (I) was lost saw the deceased alive on Dec. 21, 19 66 , and that death occurred at M , from causes and on the date stated above.					
22a. SIGNATURE Edward S. Beck		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-22-66	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22d. ADDRESS 73 Franklin St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Sater's Cemetery	
23d. LOCATION (City or Town) Lutherville, Md.		(County)		(State)	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		25a. REC'D BY REGISTRAR DATE DEC 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16556 **CERTIFICATE OF DEATH** **16556**

Item 2 Film 6384 12/22/66

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL ANNAPOLIS, MD.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND c. STREET ADDRESS U. S. Naval Academy Supt. Quarters, BAY RIDGE NURSING HOME d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle D. Last KAUFFMAN		4. DATE OF DEATH Month DECEMBER Day 9 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 MAY 1885
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (County & State, or foreign country) SAN FRANCISCO CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME T. WALN-MORGAN DRAPER		14. MOTHER'S MAIDEN NAME LOUISE H. KELSEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 193 26 0187	
17. INFORMANT RADM D. L. KAUFFMAN, USN		Address 1 BUCHANAN ROAD USNA ANNA. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2 DEC 66 , 19 66 , to 9 DEC , 19 66 , that (I) (we) last saw the deceased alive on 9 DEC 19 66 , and that death occurred at 12:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Barry John Coughlin		22b. DATE SIGNED 9 DEC 66	
22c. PHYSICIAN'S NAME (Type) LT. BARRY J. COUGHLIN		22d. ADDRESS NAVAL HOSPITAL ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12-12-66	23c. NAME OF CEMETERY OR CREMATORY U.S.N. ACADEMY	23d. LOCATION (City, town or county) (State) ANNAPOLIS MD.
24. FUNERAL DIRECTOR John M. Lyons Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DEC 14 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16556

CERTIFICATE OF DEATH

16557

1. PLACE OF DEATH a. COUNTY Crownsville State Hos. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSTOWN		c. LENGTH OF STAY IN lb SEVEN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hosp		d. STREET ADDRESS Rt. #2 Box 79	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah F. Kellman		4. DATE OF DEATH Month December Day 25 Year 1966	
5. SEX Female	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1924
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 42 Days 42 Hours 42 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) East Spencer, N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ed. Boggs		14. MOTHER'S MAIDEN NAME SALLIE McKenna	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 130-14-9567	
17. INFORMANT JOAN SPURLIN, Same AS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, Convulsions, Pyrexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 492X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/25/66 , 19, to 12/25/66 , 19, that (I) (we) last saw the deceased alive on 12/25/66 , and that death occurred at 5:00 M, from causes and on the date stated above.			
22a. SIGNATURE L. BENEDICT M.D.		22b. DATE SIGNED 12/27/66	
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		22d. ADDRESS Crownsville State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 29, 1966	
23c. NAME OF CEMETERY OR CREMATORY Rowan Memorial Cemetery,		23d. LOCATION (City or Town) (County) (State) Salisbury, North Carolina	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR JAN 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF LOSS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G384 12/27/66 mh

16557

CERTIFICATE OF DEATH

16558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 19 years 5 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 519 Normandy Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) #10507 Daisy First Middle Last King		4. DATE OF DEATH Month Day Year 12 19 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/1881
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome sec. Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/7/1947 , to 12/19/1966 , that (I) (we) last saw the deceased alive on 12/19/1966 , and that death occurred at 12:10 from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 12/19/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/23/66	St. Lukes Cem	Balto. Md
24. FUNERAL DIRECTOR Earl Gilmore		25a. REC'D BY REGISTRAR DEC 19 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16558

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 27 yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 709 BERRY RD			d. STREET ADDRESS 709 Berry Road		
3. NAME OF DECEASED (Type or print) First MARY Middle M Last King			4. DATE OF DEATH Month Dec. Day 2 Year 19 66		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1890	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Calvert Co., Md.	
13. FATHER'S NAME Joseph Armiger			14. MOTHER'S MAIDEN NAME Margaret Trott		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes: give war or dates of service)		16. SOCIAL SECURITY NO. 216-18-4529D		17. INFORMANT Mrs. Clarence Thomas, 709 Berry Road, Glen Burnie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Coronary - heart disease DUE TO (c) Coronary - heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 , to 1966 that (I) (we) last saw the deceased alive on Sept. 19 66 , and that death occurred at 6:45 P M, from causes and on the date stated above.					
22a. SIGNATURE Ernest Leipold			22b. DATE SIGNED 12-2-66		22c. PHYSICIAN'S NAME (Type) Ernest Leipold
22d. ADDRESS Glen Burnie, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 5, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Chr. Cemetery Owings, Calvert Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Hitchins Funeral Home Owings, Md.			25a. REC'D BY REGISTRAR DEC 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16558

TECHNICAL OF RECORD

16558

Anna Hunsford

Married

Wife of

John Hunsford

27 yrs.

John Hunsford

709 Perry Road

N

John Hunsford

X

John Hunsford

Honorable

Honorable

Calvert Co., Md.

Joseph Hunsford

Married

210-11-1200 Mr. Clarence Thomas, Calvert Co., Md.

Handwritten signature: Clarence Thomas

John Hunsford

Handwritten signature: John Hunsford

John Hunsford, Maryland

John Hunsford

John Hunsford, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, if retained by the hospital or attending physician, must be signed by the attending physician and completely filled in by the funeral director. Page 5, if retained by the funeral director, must be signed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16559 CERTIFICATE OF DEATH 16560

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Linthicum</u>	
c. LENGTH OF STAY IN lb <u>4 1/2 M.</u>		d. STREET ADDRESS <u>14 Balto. Annapolis Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14 Baltimore & Annapolis Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Salome Krippes</u>	First Middle Last	4. DATE OF DEATH <u>Dec 22 1966</u>	Month Day Year
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22 1875</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>215-50-4886-T</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Winchester Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John D. Good</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Good</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-50-1886</u>	
17. INFORMANT <u>Conzuela T. Webster - Linthicum Spd.</u>		Address <u>14 B & A Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 mos</u> <u>10-15 M.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio - Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1934</u> to <u>12/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>66</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles L. Ball Jr.</u>		22d. ADDRESS <u>Linthicum Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 24, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy. A. A. Co., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		ADDRESS <u>4001 Ritchie Hwy.</u>	
24. REC'D BY REGISTRAR <u>DEC 28 1966</u>		25. REGISTRAR'S SIGNATURE <u>Charles J. Gonce</u>	

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16561

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Route 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last FLOYD MITCHELL LAMBERT				4. DATE OF DEATH Month Day Year December 15, 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/12	9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drawbridge Operator State Road			10b. KIND OF BUSINESS OR INDUSTRY Mill Creek Rd. W. Va		11. BIRTHPLACE (State or foreign country) USA		
13. FATHER'S NAME John Marshall Lambert			14. MOTHER'S MAIDEN NAME Rachel Curence				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Elwood U Lambert Tracy Landing Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 812.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car				
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 12-13 1966			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) - Anne Arundel Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate			M.D. Charles S. Springate, M.D.				
EXAMINER'S NAME (Type)			22. DATE SIGNED December 16, 1966				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12		23c. NAME OF CEMETERY OR CREMATORY Wood Side		23d. LOCATION (City or Town) (County) (State) Adlesville Md.
24. FUNERAL DIRECTOR Bernard Adamsky Adlesville Md.			ADDRESS		25a. REC'D BY REGISTRAR DEC 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11, 12, 13, 14 Film G383 12/19/66 mh

FOR STATE
HEALTH DEPT.

16561

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16562

1. PLACE OF DEATH a. COUNTY <i>A.A.Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>A.A.Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL.</i>		c. LENGTH OF STAY IN 1b <i>Several Maryland.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>D.O.M. - NORTH ARUNDEL - HOS P.</i>		d. STREET ADDRESS <i>404 Clark Station -</i>	
3. NAME OF DECEASED (Type or print) First <i>Ann</i> Middle <i>Landerhink</i> Last <i>Landerhink</i>		4. DATE OF DEATH Month <i>12</i> Day <i>10</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-26-60</i>
9. AGE (In years lost birthday) yrs. <i>6</i>		IF UNDER 1 YEAR Months <i>6</i> Days <i>10</i> Hours <i>19</i> Min. <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Guy W. Landerhink</i>		14. MOTHER'S MAIDEN NAME <i>Melvinia Howard</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give war or dates of service))		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries.</i> 812.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Subject ran in front of car</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>1</i> p.m. <i>12-10-66</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) (County) (State) <i>A.A. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. L. W. Landerhink</i> EXAMINER'S NAME (Type)		22. DATE SIGNED <i>12-10-66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/13/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>
24. FUNERAL DIRECTOR <i>McClully F.H. 237 Patapsco Ave.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 14 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16562 1. PLACE OF DEATH a. COUNTY <u>Anne Arundell</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>45 Lochleven Rd.</u>		16563 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>45 Lochleven Drive</u> d. STREET ADDRESS <u>Severna Park</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christine</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 27, 1912</u> 9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH <u>12-19-66</u> 19 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTH PLACE (County & State, or foreign country) <u>New York, N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Nightingale</u> 14. MOTHER'S MAIDEN NAME <u>IRMA FURNION</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Robert J. LaPorte</u> Address <u># 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 157x DUE TO (b) <u>Carcinoma of the Head of the Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19, to <u>1966</u> , 19, that (I) (we) last saw the deceased alive on <u>12-8-66</u> , 19, and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Halpin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Robert R. Halpin</u> 22d. ADDRESS <u>P.O. Box 73 Severna Park Md</u>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> 23b. DATE THEREOF <u>12-21-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> 23d. LOCATION (City, town or county) (State) <u>BLADENSBURG MD.</u>		25a. REC'D BY REGISTRAR <u>John M. Lyles</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>DEC 23 1966</u>	

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PROJECT 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16563			CERTIFICATE OF DEATH				16564		
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 2yrs. 7 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 839 Central Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) #27329 Elizabeth Lee First Middle Last 4. DATE OF DEATH 12 26 66 Month Day Year					5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2/12/1912 9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ambrose Lee					14. MOTHER'S MAIDEN NAME Miller				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardio-Vascular Disease - Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443 X (c) XXXX DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mental Deficiency; Chronic Brain Syndrome								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) -----		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/12/1964 , to 12/26/1966 , that (I) (we) last saw the deceased alive on 12/26/1966 , and that death occurred at 3:50 M, from causes and on the date stated above.									
22a. SIGNATURE L. Benedict, M.D.					22b. DATE SIGNED 12/29/66			22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 2/15/67		23c. NAME OF CEMETERY OR CREMATORY Ch. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR William Reese II 108 N. York St. Annapolis, Md.					25a. REC'D BY REGISTRAR JAN 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16564

CERTIFICATE OF DEATH

16565

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE		c. LENGTH OF STAY IN 1b 13 WKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum 02.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knollwood Nursing Home				d. STREET ADDRESS 314 E. Hilltop Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Hodges Linthicum				4. DATE OF DEATH Month Day Year 12/ 30/ 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1875	
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (ret)	
10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (County & State, or foreign country) Glen Burnie, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howell Hodges				14. MOTHER'S MAIDEN NAME Martha Bond			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address: 314 E Hilltop Rd. Mr. Howell Linthicum Linthicum, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary artery occlusion DUE TO (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 30	
21. I certify that (I) (this hospital) attended the deceased from 10/8 , 19 66 , to 12/14 , 19 66 , that (I) (we) lost the deceased alive on 02/14/66 19 66 , and that death occurred at 12/14/66 M, from causes and on the date stated above.							
22a. SIGNATURE Ray M. Smith				22b. DATE SIGNED 12/30/66		22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.	
22d. ADDRESS Hahn Pro. Bldg. Severna Park, Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Brooklyn RD. Md.	
24. FUNERAL DIRECTOR R. V. Singleton				25a. REC'D BY REGISTRAR Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. DATE JAN 4 1967				25d. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1856

1856

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16565

CERTIFICATE OF DEATH

16566

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ODENTON, MARYLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ODENTON, MARYLAND</u>	
c. LENGTH OF STAY IN 1b <u>2 YRS</u>		d. STREET ADDRESS <u>493 SALTOUN AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK VINCENT MAHONEY</u>		4. DATE OF DEATH <u>Dec. 9 1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9-01</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Postal Supervisor U.S. Post Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DENNIS MAHONEY</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA O'NEILL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Never</u>	
16. SOCIAL SECURITY NO. <u>131-22-9466A</u>		17. INFORMANT <u>RICHARD GUINNESS, Odenton, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema, Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> , 19 <u>66</u> , to <u>11/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>66</u> , and that death occurred at <u>9A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>12/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, MD</u>		22d. ADDRESS <u>59 Franklin St, Annapolis, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-13-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>New York New York</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. Baltimore, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 12 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10200

STATE OF NEW YORK

10200

IN SENATE,
January 10, 1900.
REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE,
MAY 1, 1899.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16566

CERTIFICATE OF DEATH

16567

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3 years 3 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #26020 Christine Martin		4. DATE OF DEATH Month 12 Day 22 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/28 (1927)
9. AGE (In years lost birthday) 38 (39) ys.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Evans		14. MOTHER'S MAIDEN NAME Florence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-6201E	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Abscess and Pneumonitis 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell Carcinoma of Floor of Mouth DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Dehydration and Inanition			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 11	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 9/12/63 , to 12/22/66 , that (I) (we) last saw the deceased alive on 12/22/1966 , and that death occurred at 2:20 P. M, from causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp		22b. DATE SIGNED 12/22/66	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-29, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Anthony's	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Henry O. Wilson		25a. REC'D BY REGISTRAR DEC 29 1966	
ADDRESS 1000 Baitley Ave		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16567

16568

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> 02.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>23 FRANCIS ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CECIL MERRITT McCANDLESS</u>		4. DATE OF DEATH Month Day Year <u>12 18 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LAURENCE McCANDLESS</u>		14. MOTHER'S MAIDEN NAME <u>MARY KIRKPATRICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MRS. VIRGINIA SIMON</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated duodenal ulcer</u> DUE TO (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 1966, to <u>12/18</u> , 1966, that (I) (we) last saw the deceased alive on <u>12/18</u> , 1966, and that death occurred at <u>5:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>12/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-21-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NORTH CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BUTLER TOWNSHIP P.A.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR <u>DEC 21 1966</u>	
ADDRESS <u>Ann Arundel Co. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1850

[Faint, illegible handwriting on lined paper]

16568

CERTIFICATE OF DEATH

16569

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN tb <u>45 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>601 Kuethe Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>601 Kuethe Rd.</u>											
3. NAME OF DECEASED (Type or print) <u>MARIE</u> First Middle Last 4. DATE OF DEATH <u>Dec. 24</u> Month Day Year <u>1966</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>1901, Jan. 15</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, often if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>George Henry John Flynn</u>						14. MOTHER'S MAIDEN NAME <u>Refer, Lena</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-12-3894</u>				17. INFORMANT <u>Daughter</u> Address <u>601 Kuethe Road Glen Burnie, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> <u>155.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Primary hepatoma</u> (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from <u>July 1, 1964</u> to <u>Dec. 24, 1966</u> ; that (I) (we) last saw the deceased alive on <u>Dec. 23, 1966</u> , and that death occurred at <u>1:45</u> M., from the causes and on the date stated above.															
22a. SIGNATURE <u>Edmond I. Moushabeck</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABECK</u>						22d. ADDRESS <u>SIDMARLEY STATION ROAD GLEN BURNIE, MD. 21061</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>				23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy., A.A. Co., Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u> ADDRESS <u>4001 Ritchie Hwy., Baltimore</u>						25a. REC'D BY REGISTRAR <u>DEC 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16569

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16570

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>		c. LENGTH OF STAY IN 1b <i>30 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Maryland</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>none</i>				d. STREET ADDRESS <i>Ft. Smallwood Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Evelyn</i> Middle <i>Amelia</i> Last <i>Metzendorf</i>				4. DATE OF DEATH Month <i>December</i> Day <i>12</i> Year <i>1966</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>February 14, 1889</i>	
9. AGE (in years last birthday) <i>77 yrs.</i>		10. IF UNDER 1 YEAR Months <i>77</i> Days <i>77</i> Hours <i>77</i> Min. <i>77</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Lewis Dehn</i>				14. MOTHER'S MAIDEN NAME <i>Jane Trombo</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> <i>420.0</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>arteriosclerotic heart disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 18, 1966</i> to <i>Dec. 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 8, 1966</i> , and that death occurred at <i>6 P.</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>R.M. McLaughlin</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/12/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>				22d. ADDRESS <i>3705 Mountain Rd. Pasadena, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/16/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem</i>		23d. LOCATION (City, town or county) (State) <i>A A Co Md</i>	
24. FUNERAL DIRECTOR <i>McCully Funeral Home 237 Patapsco Ave 21225</i>				25a. REC'D BY REGISTRAR <i>DEC 15 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

16333

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Large family

Large family

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Family

Cedar Hill Co

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1816

No. 1017, General Home 237, Patented Nov 1893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16570

Item 6 Film G204 1/3/67 mh

16571

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hill</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hill</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6210 Eldridge Road</u>			d. STREET ADDRESS <u>6210 Eldridge Road</u>		
3. NAME OF DECEASED (Type or print) <u>Florence Middleton</u>			4. DATE OF DEATH <u>12/23</u> 19 <u>66</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>Negro</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9/22/1904</u>		
9. AGE (In years, last birthday) <u>62</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <u>Charles County Md</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Albert Warrington</u>			14. MOTHER'S MAIDEN NAME <u>Christina Jennifer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Mary Fuller</u>			Address <u>6210 Eldridge Road</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Hemorrhage</u> (a), stating the underlying cause last. (c) <u>Hypertensive CardioRenal Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>Day</u> <u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9-6-</u> 19 <u>66</u> to <u>12-23-</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-23-</u> 19 <u>66</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Richard H. Hunt</u>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>R. Richard H. Hunt</u>			22d. ADDRESS <u>100 Cherry Lane, Glen Burnie Md</u>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/28/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl Cem</u>			23d. LOCATION (City, town or county) (State) <u>5501 Federal Ex</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Elukor</u>			ADDRESS <u>1129 N. Caroline St</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE		
DATE <u>DEC 28 1966</u>											

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16577

16572

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Lethian				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sands Road - Route 1 - Box 51				e. STREET ADDRESS Sands Road - Route 1 - Box 51			
3. NAME OF DECEASED (Type or print) First Middle Last BRYAN EDWARD MORELAND				4. DATE OF DEATH Month Day Year Dec. 11 19 66			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5-1964	9. AGE (In years last birthday) 2 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
13. FATHER'S NAME George E. Moreland				14. MOTHER'S MAIDEN NAME Vivian H. Powell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Annie L. Moreland-Box 51-Rt.1 Lethian, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bureau 3rd ° Lethian 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Under	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) House fire					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) AD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 22. DATE SIGNED 12-11-66							
ACTUAL SIGNATURE E.G. LINHARDT		EXAMINER'S NAME (Type) E.G. LINHARDT - Annapolis, Md. Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 12-66		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town or county) (State) Lethian, Maryland	
24. FUNERAL DIRECTOR ADDRESS C.E. Hicks 111 Annapolis, Maryland				25a. REC'D BY REGISTRAR DEC 14 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 18064
16572
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deep Cove Rd. Churchton, P.O.</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deep Cove Rd. Churchton, P.O.</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Elizabeth MORRIS</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-1900</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Corbinville, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Walter Braddfield</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bittoff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-03-1416</u>	
17. INFORMANT <u>Alonzo Morris</u>		Address <u>Deep Cove Rd Churchton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO <u>and diabetes mellitus</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(husband)</u> attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>Dec 21</u> , 19 <u>66</u> , that (I) <u>(husband)</u> last saw the deceased alive on <u>Dec. 19</u> , 19 <u>66</u> , and that death occurred at <u>5:4</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>Willard F. Smith</u>	
22b. DATE SIGNED <u>12/21/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, M.D.</u>	
22d. ADDRESS <u>Shady Side, Md.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-23-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		23d. LOCATION (City or Town) (County) (State) <u>Halesville AA Md.</u>	
24. FUNERAL DIRECTOR <u>Bernard O Hardesty Halesville Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

57231

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16573

16573

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>////////</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>10 Kellington Drive</u>	
3. NAME OF DECEASED (Type or print) <u>HENRY THOMAS MYERS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer (Ret.)</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Glen Burnie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry J. Myers</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Wade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW1</u>		16. SOCIAL SECURITY NO. <u>216-098283</u>	
17. INFORMANT <u>Mrs. Doris Kellenberger (daughter) G.B.</u>		Address <u>1506 Jupp Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>20 Min</u> <u>5 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>Dec 30</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>Dec 16</u> , 19 <u>66</u> , and that death occurred at <u>11 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward G. Skerritt</u>		22b. DATE SIGNED <u>12-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward G. Skerritt M.D.</u>		22d. ADDRESS <u>Cambills Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 4 1967</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10234

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16574

CERTIFICATE OF DEATH

16574

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Solomon Middle NICHOLS Last NICHOLS		4. DATE OF DEATH Month December Day 27 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Nichols		14. MOTHER'S MAIDEN NAME Annie Gayce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. 218.05.477	
17. INFORMANT Halsey Nichols		Address Mayo Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Generalized Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 199.2		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from June 18, 1965 to Dec. 27, 1966 that (I) (we) saw the deceased alive on Dec. 27, 1966 , and that death occurred at 5:50 AM , from causes and on the date stated above.			
22a. SIGNATURE R. L. Richardson		22b. DATE SIGNED 12/27/66	
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D.		22d. ADDRESS 110 Clay St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-30-66	23c. NAME OF CEMETERY OR CREMATORY Pine Lawn	23d. LOCATION (City or Town) (County) (State) Annapolis Md.
24. FUNERAL DIRECTOR William Reese #		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 28 1966	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16574

DEPARTMENT OF AGRICULTURE

16574

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16575

CERTIFICATE OF DEATH

16575

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ann S. OSHRY		4. DATE OF DEATH Month December Day 20 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 20 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mayer S. Rocklin		14. MOTHER'S MAIDEN NAME Fannie Rosen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 141-16-1743	
17. INFORMANT Eliot Siskind		Address #1 Baldrige Rd. Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) Coronary artery atherosclerosis DUE TO (c) 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his/her) attended the deceased from 1956 , 19 Dec. 6 , 19 66 that (I) (was) last saw the deceased alive on Dec. 6 , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE John L. Hedeman		22b. DATE SIGNED 12/20/66	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/22/66	23c. NAME OF CEMETERY OR CREMATORY Ohel Yakov	23d. LOCATION (City or Town) (County) (State) Herring Run, Balto. Md.
24. FUNERAL DIRECTOR JACK LEWIS, INC. 2100 Eutaw Place Balto. Md.		25a. REC'D BY REGISTRAR DATE DEC 22 1966	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10573

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
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15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16576

16576

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u> c. LENGTH OF STAY IN lb <u>1808 popular Ave</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bay Manor Care Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Ch. Ch.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>1808 popular Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha Parker</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>4</u> Day <u>12</u> Year <u>1881</u>
9. AGE (In years, say birthday) <u>85</u> yrs.		10. AGE (In years, say birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rutland Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Louise Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>70</u>	
17. INFORMANT <u>Lillian Booth</u>		Address <u>1808 popular Ave</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unlabeled</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unlabeled</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> 19 <u>66</u> , to <u>12/25</u> 19 <u>66</u> , that (I) (two) last saw the deceased alive on <u>12/18</u> 19 <u>66</u> , and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>12/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman</u>		22d. ADDRESS <u>59 Franklin St. Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-29-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Burial Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 28 1966</u>	

18838

CERTIFICATE OF DEATH

18838

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16577

CERTIFICATE OF DEATH

16577

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b UNKNOWN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. NAVAL ACADEMY, ANNAPOLIS, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND d. STREET ADDRESS 807 WEST STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CARL WILSON PEDDICORD				4. DATE OF DEATH Month Day Year DECEMBER 6 19 66			
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 19, 1915	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) OWENSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN				10b. KIND OF BUSINESS OR INDUSTRY US Gov't. ELECTRICAL MAINTENANCE		11. BIRTHPLACE (County & State, or foreign country) OWENSVILLE, MARYLAND	
13. FATHER'S NAME Louis Henry Peddicord				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Greenwell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT SAFETY OFFICER, U. S. NAVAL ACADEMY, ANNA., MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSECTING AORTIC ANEURYSM 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) OR MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							INTERVAL BETWEEN ONSET AND DEATH 30-40 MIN.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 6 DECEMBER , 19 66 , to 6 DECEMBER , 19 66 , that (I) (the) last saw the deceased alive on 6 DECEMBER , 19 66 , and that death occurred at 1240 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Florent Franklin Westfall Jr.</i> M.D.				22b. DATE SIGNED 6 DECEMBER 1966		22c. PHYSICIAN'S NAME (Type) F. F. WESTFALL, JR., LCDR, MC, USN	
22d. ADDRESS U. S. NAVAL ACADEMY, ANNAPOLIS, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Beverley E. Hopping Hopping Funeral Home		25a. REC'D BY REGISTRAR DEC 8 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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UNITED STATES

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NAVY

ANNAPOLIS, MARYLAND

UNION

ANNAPOLIS

U. S. WEST ST. ST.

U. S. NAVAL ACADEMY, ANNAPOLIS, MARYLAND

DECEMBER

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APRIL 13, 1918

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F. F. ESTELL, JR., LCDR, U. S. NAVAL ACADEMY, ANNAPOLIS, MARYLAND

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16578

CERTIFICATE OF DEATH

16578

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 4 mos. 15 das.		d. STREET ADDRESS 1015 E. Monement Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #25942 Thomas Pennix First Middle Last		4. DATE OF DEATH Month 12 Day 14 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years lost birthday) 67?		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborem known		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Maryland N Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown John Pennick		14. MOTHER'S MAIDEN NAME Unknown Emma Trollinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 212-22-9399	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) C.B.S. due to Cerebral Arteriosclerosis and C.N.S. - Syphilis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to Cerebral Arteriosclerosis and C.N.S. - Syphilis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/29/63 , to 12/14/1966 , that (I) (we) last saw the deceased alive on 12/14/1966 , and that death occurred at 7:30M , from causes and on the date stated above.			
22a. SIGNATURE L. Benedict		22b. DATE SIGNED 12/14/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/66	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) A A County Md	
24. FUNERAL DIRECTOR A. Halstead		25a. REC'D BY REGISTRAR DEC 16 1966	
ADDRESS 1206 W. North Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16579

CERTIFICATE OF DEATH

16579

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodland Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		d. STREET ADDRESS <u>02.1</u>	
3. NAME OF DECEASED (Type or print) First <u>Letitia</u> Middle <u>Riley</u> Last <u>Riley</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22 1891</u>
9. AGE (In years last birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Barrow</u>		14. MOTHER'S MAIDEN NAME <u>Letitia Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>John F Riley</u>		Address <u>Wells N.Y.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho-pneumonia</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-10</u> , 19 <u>62</u> , to <u>Dec 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 4</u> , 19 <u>66</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Emily H. Wilson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Removal</u>	<u>12-5-66</u>	<u>Riley Mortuary</u>	<u>110 Division St. Amsterdam NY</u>
24. FUNERAL DIRECTOR <u>HARDESTY Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE	

13258

1023

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 yrs. 11mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown / Baltimore 11			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1000 W. 42nd Street Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #23800 Marjorie		First Middle Lost Roberts		4. DATE OF DEATH Month 12 Day 12 Year 19 66			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/14/1917	
9. AGE (In years as of birthday) yrs. 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration and Inanition 2959 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Refused to take food or Fluids (c) Schizophrenic reaction - Chronic Undifferentiated Type							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 3007 Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/15/ 19 62 , to 12/12/66 , 19__, that (I) (we) last saw the deceased alive on 12/12/ 1966 , and that death occurred at 3:30 M, from causes and on the date stated above							
22a. SIGNATURE Lionel McHenry Mapp				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/12/66	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.				22d. ADDRESS Crownsville, Maryland			
23a. BURIAL, CREMATION, (REMOVAL) (Specify) REMOVAL		23b. DATE THEREOF 12-16-66		23c. NAME OF CEMETERY OR CREMATORY Chapel Grove		23d. LOCATION (City or Town) (County) (State) Windsor Isle of Wight, Va.	
24. FUNERAL DIRECTOR Edith K. Tyree Smithfield, Virginia				25a. REC'D BY REGISTRAR JUL - 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-371101)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text block containing several lines of typed information, possibly a memorandum or report body.]

Very truly yours,
[Illegible Signature]
Special Agent in Charge
[Illegible text block containing administrative markings, dates, and possibly a routing slip.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16580					16580				
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 3 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 26 W. Washington Street					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 26 W. Washington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ALICE ROSS SMITH RODRIQUES			4. DATE OF DEATH Dec. 8 1966		9. AGE (In years last birthday) 70 IF UNDER 1 YEAR: Months Days Hours Min.				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 10-1896		11. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY *****		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Smith				14. MOTHER'S MAIDEN NAME Martha Gantt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hattie Phree-26 W. Washington-Anna. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Heart Failure 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) H.I. A. C. U. D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 5 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 10-10 , 19 66 , to 12-8 , 19 66 that (I) (we) last saw the deceased alive on Dec. 8 , 19 66 , and that death occurred at 1 A.M. , from the causes and on the date stated above.									
22a. SIGNATURE Faye W. Allen				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Faye Allen			
22d. ADDRESS Cathedral Street Annapolis, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 12-66		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) (State) Annapolis, Md.			
24. FUNERAL DIRECTOR C.E. Hicks 111 Annapolis, Md.				25a. REC'D BY REGISTRAR DEC 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16581

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b /// //		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 965 Princeton Terrace			
3. NAME OF DECEASED (Type or print) First Richard Middle J. Last Ronquillo				4. DATE OF DEATH Month 12 Day 23 Year 1966			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9 1949	9. AGE (In years last birthday) x8 17 yrs.	IF UNDER 1 YEAR Months 12 Days 23 Hours 17 Min.		IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hardware Fair		11. BIRTHPLACE (State or foreign country) Cal.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jose Ronquillo				14. MOTHER'S MAIDEN NAME Myrtle Chestnut			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none		16. SOCIAL SECURITY NO. 216-48-8081		17. INFORMANT Address Mr. Jose Ronquillo (Father) Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral injury DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) driver in auto-auto collision						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver in auto-auto collision		20c. TIME OF INJURY Month, Day, Year 10:00 Hour 12 Day 23 Year 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Brooklyn Pk. A.A. Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county) Glen Burnie, Md.		22. DATE SIGNED 12/25/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 28, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR R.V. Singleton		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DEC 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16582

16582

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Caroline Co.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GREENSBORO			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAVAL HOSPITAL				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First ANNA Middle MARIE Last ROSTIEN				4. DATE OF DEATH Month DEC Day 16 Year 19 66			
5. SEX FEMALE		6. COLOR OR RACE CAUC		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 NOV 1887	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Adam Strohmeier		14. MOTHER'S MAIDEN NAME Helena Mageldina			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address SON RICHARD A. ROSTIEN GREENSBORO MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 199.2 DUE TO (b) Constrictive Heart failure DUE TO (c) Disseminated Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphocytic Leukemia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 16 DECEMBER, 19 66 , to 16 DECE. , 19 66 that (I) (we) last saw the deceased alive on 16 DEC 19 66 , and that death occurred at 1105M , from the causes and on the date stated above.							
22a. SIGNATURE Michael F. Fornes M.D.						22b. DATE SIGNED 16 DEC 66	
22c. PHYSICIAN'S NAME (Type) LCDR M.F. FORNES, MC USN						22d. ADDRESS NAVAL HOSPITAL ANNAPOLIS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-19-66		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town or county) (State) Greensboro, Md.	
24. FUNERAL DIRECTOR John E. Boulais				25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

13532

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G384 12/30/66 mh

16583

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16583

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Miller sville				c. LENGTH OF STAY IN 1b 02.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Millersville, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Rudorf Last Rudorf				4. DATE OF DEATH Month Dec. Day 25 Year 19 66			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 1, 1884	
9. AGE (In years lost birthday) 82 83 yrs.		IF UNDER 1 YEAR Months 82 Days 83		IF UNDER 24 HRS. Hours 82 Min. 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-48-2145		17. INFORMANT Mrs. Myrtle E. Deinlein - Millersville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO arteriosclerosis jammed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO arteriosclerosis (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. Hopping		EXAMINER'S NAME (Type) E. Hopping		M.D. E. Hopping		22. DATE SIGNED 12/25/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/66		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR Beverly E. Hopping Hopping Funeral Home				25a. REC'D BY REGISTRAR DEC 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Richardson

Richardson

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2d Film G384 1/3/67 mh

16584

CERTIFICATE OF DEATH

16585

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS Md</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>				d. STREET ADDRESS <u>109 Maple Lane VAN BUREN PARK RIDGE</u>			
3. NAME OF DECEASED (Type or print) <u>Willie S. Schneck</u>				4. DATE OF DEATH <u>DEC 22 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 23 1879</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>				13. FATHER'S NAME <u>Charles Schneck</u>			
14. MOTHER'S MAIDEN NAME <u>Caroline Scheidt</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No None</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>VAN BUREN</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infirmities of age</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smear & coronary arteries cleared</u>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/12, 1965</u> to <u>12/22, 1966</u> that (I) (we) last saw the deceased alive on <u>11/21, 1966</u> and that death occurred at <u>12/22, 1966</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Maurice F. Klawans</u> M.D.				22b. DATE SIGNED <u>12/22/66</u>		22c. PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>	
22d. ADDRESS <u>31 SOUTHGATE AV. ANNAPOLIS</u>				22e. REGISTRAR'S SIGNATURE <u>James Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Wm. J. Tibnerd Sons Baltimore, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 27 1966</u> DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16585

CERTIFICATE OF DEATH

16586

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Hiram Last SEEDERS				4. DATE OF DEATH Month December Day 8 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1867	
9. AGE (In years last birthday) 99 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mineral Co West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Ebenezer Seeders		14. MOTHER'S MAIDEN NAME Sarah Ellen Baker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs J. L. Barksdale Address Lothian Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec. 8 , 19 66 , to Dec. 8 , 19 66 , that (I) (we) last saw the deceased alive on Dec. 8 , 19 66 , and that death occurred at 4:50 AM M, from causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) [Signature]				22d. ADDRESS 100 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-66		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby		23d. LOCATION (City or Town) (County) (State) Fort Ashby N. C.	
24. FUNERAL DIRECTOR Hardesty Funeral Home, Gaithersburg, Md				25a. REC'D BY REGISTRAR DATE DEC 19 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
16586
16587
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ft Geo G Meade, Maryland c. LENGTH OF STAY IN 1b 56 minuets d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kimbrough AH, Ft Geo G Meade, Md.				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MO. b. COUNTY St Louis, Mo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St Louis, Mo. d. STREET ADDRESS 5317 Cote Brilliant Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marion Porter Simmons				4. DATE OF DEATH Month December Day 23 Year 19 66			
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 July 1944		9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (County & State, or foreign country) ST LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marion Simmons				14. MOTHER'S MAIDEN NAME Besie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES		16. SOCIAL SECURITY NO. 493-46-0659		17. INFORMANT Besie Simmons(M) 5317 Cote Brilliant Street St Louis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthmations DUE TO Allergic Reaction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Minuets
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that MD (this hospital) attended the deceased from 7:04 hrs 23 Dec 1966 to 8:10 hrs 23 Dec 66 that xx (we) last saw the deceased alive on 23 Dec 1966 , and that death occurred at 8:10 PM from the causes and on the date stated above.							
22a. SIGNATURE Stuart H Brager, Cpt, MC				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 23 Dec 66	
22c. PHYSICIAN'S NAME (Type) STUART H. BRAGER, CPT, MC				22d. ADDRESS Kimbrough AH, Ft Geo G. Meade, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC.30,1966		23c. NAME OF CEMETERY OR CREMATORY JEFFERSON BARRACKS NATIONAL		23d. LOCATION (City, town or county) (State) ST. LOUIS, MISSOURI	
24. FUNERAL DIRECTOR'S SIGNATURE Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland				25a. REC'D BY REGISTRAR JAN 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16587

CERTIFICATE OF DEATH

16588

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in 1b 4 years 9 mos. 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 1021 N. Castle Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #23478 Benjamin Wise Smith First Middle Last				4. DATE OF DEATH Month 12 Day 16 Year 19 66			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1937		9. AGE (In years last birthday) yrs. 28 2/5	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Smith				14. MOTHER'S MAIDEN NAME Lillian			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-34-0619		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Congestive Heart Failure DUE TO (b) Hypertension DUE TO (c) Glomerulodnephritis, Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Schizophrenia Reaction, Chronic Undifferentiated							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year How am p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 3/21/1962 , to 12/16/1966 , that (I) (we) last saw the deceased alive on 12/16/1966 , and that death occurred at 5:15 M. from causes and on the date stated above.							
22a. SIGNATURE [Signature]				a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/16/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.				22d. ADDRESS Crownsville State Hospital, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-21-66		23c. NAME OF CEMETERY OR CREMATORY Calvary Cut		23d. LOCATION (City or Town) (County) (State) md	
24. FUNERAL DIRECTOR E. J. Wilson				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE [Signature]	
ADDRESS 1000 Brantly av				DATE DEC 19 1966			

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Harry Specht

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16588

CERTIFICATE OF DEATH

16589

1. PLACE OF DEATH a. COUNTY AA Co b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAGH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY AA Co c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS 1214 Riverside Dr Och Bch e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry First M Middle Specht Last		4. DATE OF DEATH Dec Month 6 Day 19 Year 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 1, 1893
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Mln. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng		10b. KIND OF BUSINESS OR INDUSTRY Balto Gas & Elec	
11. BIRTHPLACE (County & State, or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Aaron Specht		14. MOTHER'S MAIDEN NAME Emma Rahausen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Family	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 177X DUE TO Coronary arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO adenocarcinoma of the prostate gland PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 months 3 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/18 , 19 58 , to 12/6 , 19 66 , that (I) (we) last saw the deceased alive on 12/3 , 19 66 , and that death occurred at 5 P. M, from the causes and on the date stated above.			
22a. SIGNATURE R. M. McLaughlin		22b. DATE SIGNED 12/7/66	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin		22d. ADDRESS 3708 Mountain Road Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 12/9/66	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem	23d. LOCATION (City, town or county) (State) Balto Co Md
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225		25a. REC'D BY REGISTRAR DEC 9 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Dr. M. J. Griffin

2005-05-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16589

CERTIFICATE OF DEATH

16590

1. PLACE OF DEATH a. COUNTY <u>H. A. Co.</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>11 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		<u>02-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street/address) <u>311 Gloucester Dr.</u>				d. STREET ADDRESS <u>311-Gloucester Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Viola</u>		First <u>Elizabeth-Spriggs</u>		Middle <u>Elizabeth-Spriggs</u>		Lost <u>Dec.</u>	
4. DATE OF DEATH Month <u>Dec.</u>		Day <u>28</u>		Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>27 Sept. 1907</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u>		IF UNDER 1 YEAR Days <u>59</u>		IF UNDER 24 HRS. Hours <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cash Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ETRA J. Lille</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Reiger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-12-9722</u>		17. INFORMANT <u>John W. Spriggs - Same as 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO (b) <u>Arteriosclerosis general</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>Dec 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 15</u> 19 <u>66</u> , and that death occurred at <u>834</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Taler</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/30/1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH TALER</u>		22d. ADDRESS <u>95 Annapolis Rd. Glen Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 31 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Balts. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert P. Singleton</u>		ADDRESS <u>Funeral Home / Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

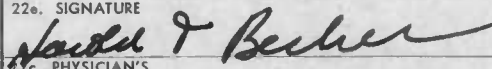
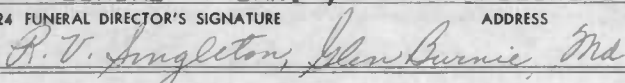
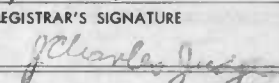
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16590

16591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE c. LENGTH OF STAY IN 1b 17 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN d. STREET ADDRESS ROUTE #3, BOX 89B e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WANDA Middle KATHERINE Last SUTLEY		4. DATE OF DEATH Month DECEMBER Day 29 Year 19 66		5. SEX FEMALE			
6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 19, 1914			
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 52 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) CLEVELAND, OKLAHOMA			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN WIPPLE		14. MOTHER'S MAIDEN NAME SARAH CATHERINE WITT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No N/A		16. SOCIAL SECURITY NO. 440-05-1021		17. INFORMANT Smith Sutley (husband) Address Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of liver DUE TO Carcinoma of breast Conditions, if any, which gave rise to immediate cause (b) 170X (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 Dec 1966 , to 29 Dec 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 29 Dec 1966 , and that death occurred at 10 p.m. from the causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) HAROLD T. BRCHER, CPT, MC		22b. DATE SIGNED 30 Dec 66		22d. ADDRESS KIMBROUGH AH, FCGMMD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY ARILINGTON NAT'L CEM.			
23d. LOCATION (City, town or county) FORT MYERS, VA.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE  24b. ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE JAN 4 1967		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
16591					16593					
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>					
c. LENGTH OF STAY IN 1b <u>15 months</u>					d. STREET ADDRESS <u>Elyaton Road</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bay Manor Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Winston</u> First <u>—</u> Middle <u>—</u> Last <u>Wade</u>					4. DATE OF DEATH <u>Dec. 2</u> 19 <u>66</u> Month <u>Dec</u> Day <u>2</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 Oct. 1904</u>		9. AGE (in years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Severn Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ira Wade</u>					14. MOTHER'S MAIDEN NAME <u>Alice Drvall</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Russell C. Wade, same as 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia at lower lobe</u> 434.1 OUE TO (b) <u>Pulmonary edema</u> OUE TO (c) <u>congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>										
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23, 1965</u> , to <u>Dec. 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 30, 1966</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Ray M. Smith</u>					22b. DATE SIGNED <u>12/2/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Ray M. Smith, M.D.</u>					22d. ADDRESS <u>Severna Park, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5 Dec. 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u> ADDRESS					25a. REC'D BY REGISTRAR <u>DEC 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16592

CERTIFICATE OF DEATH

16594

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b 3 1/2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE (Rippling Ridge)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1254 Aster Drive (Rippling Ridge)			d. STREET ADDRESS 1254 Aster Drive		
3. NAME OF DECEASED (Type or print) First Middle Last SHARON JUNE WALSH			4. DATE OF DEATH Month Day Year December 8, 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1963		9. AGE (In years last birthday) 3 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John F. Walsh			14. MOTHER'S MAIDEN NAME SHELVA Winebrenner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. John F. Walsh (father) Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 325.5 IMMEDIATE CAUSE (a) BRAIN DAMAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) MENTAL RETARDATION DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHITIS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 6th, 19 63 , to November 23, 19 66 , that (I) (we) last saw the deceased alive on November 23, 19 66 , and that death occurred at 7:30 A.M. from causes and on the date stated above.					
22a. SIGNATURE Inge Renner			22b. DATE SIGNED Dec. 8, 1966		
22c. PHYSICIAN'S NAME (Type) Inge Renner MD			22d. ADDRESS University Hosp., Balto. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 12, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Savage, Maryland	
24. FUNERAL DIRECTOR RICHARD V. SINGLETON			25a. REC'D BY REGISTRAR GLEN BURNIE, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When these remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DATE DEC 8 1966 Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16594

CERTIFICATE OF DEATH

16596

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b 12 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMORY First Middle Last WATTS		4. DATE OF DEATH DECEMBER 6 19 66 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 30, 1885
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAGONER Mechanic (Ret)		10b. KIND OF BUSINESS OR INDUSTRY B&O RAILROAD	
11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George D. Watts		14. MOTHER'S MAIDEN NAME Elizabeth Friedhoffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 721-10-9809	
17. INFORMANT Mrs. Emma R. Watts (wife) Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, Left middle cerebral artery 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/28 , 19 66 , to 12/5 , 19 66 , that (I) (we) last saw the deceased alive on 12/5 , 19 66 , and that death occurred at 2 A M, from causes and on the date stated above.			
22a. SIGNATURE Ernest Leopold		22b. DATE SIGNED December 8, 1966	
22c. PHYSICIAN'S NAME (Type) Ernest Leopold M.D.		22d. ADDRESS 407 Crain Hwy. S/E Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR R. V. Singleton Glen Burnie, Md.		25a. REC'D BY REGISTRAR DEC 12 1966 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

20201

1923

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

16595

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16597

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AACO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto. Cal</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b <u>13.2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>313 Talbot Ave - Laurel, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Watts</u> Last <u>Watts</u>				4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-91</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Watts</u>				14. MOTHER'S MAIDEN NAME <u>Anna Vickers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-9053</u>		17. INFORMANT <u>Mrs. Thomas Watts</u> <u>8 Fairfield Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. W. H. S. J.</u> M.D. EXAMINER'S NAME (Type)				22. DATE SIGNED <u>12-10-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Witzke F.D.-4101 Edmondson Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14507

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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2
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16596

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1659

MARYLAND
16598

1. PLACE OF DEATH a. COUNTY <u>A.A.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>		c. LENGTH OF STAY IN 1b <u>02.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PINE WHITE BEACH</u>		e. STREET ADDRESS <u>PINE WHITE BEACH</u>	
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>T.</u> Last <u>WELLBROCK</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D. of C. Govt.</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Building & Grounds</u>	
13. FATHER'S NAME <u>MARTIN WELLBROCK</u>		14. MOTHER'S MAIDEN NAME <u>MARY MINK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WWI & II</u>		16. SOCIAL SECURITY NO. <u>528-09-2827</u>	
17. INFORMANT <u>William J. Holhaus</u>		18. ADDRESS <u>12650 FEDERAL DR. MONTGOMERY, ALA.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>arteriosclerosis, congested</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>12-13-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		23. ADDRESS <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-16-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>ANNAPOLIS, MD.</u>	

16556

16556

MARTIN T. WEST BROOK

Voluntarily

John

Elmhurst

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

16597

CERTIFICATE OF DEATH

16599

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Ferndale)</u>	
c. LENGTH OF STAY IN 1b <u>1 Day</u>		d. STREET ADDRESS <u>125 Alan Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERT T. WELLS</u>		4. DATE OF DEATH <u>DEC 3 19 66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-10</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M. I. Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert J. Wells</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sheehan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>016-10-6466</u>	
17. INFORMANT <u>Mrs. Bertha M. Wells (Wife)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE FROM GI. TRACT</u> DUE TO (b) <u>PORTAL HYPERTENSION</u> DUE TO (c) <u>PORTAL CIRRHOSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> , 19 <u>66</u> , to <u>12-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-3</u> , 19 <u>66</u> , and that death occurred at <u>6:35 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>E. A. Tolentino</u> M.D.		22b. DATE SIGNED <u>12-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. A. TOLENTINO, M.D.</u>		22d. ADDRESS <u>201 BALTIMORE-ANNAPOLIS, GLEN BURNIE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 6, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Springfield, Mass.</u>
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u> <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>DEC 8 1966</u>	

24221

CERTIFICATE OF DEATH

(M)

16598

16600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne/Rundell</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne/Rundell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>				c. LENGTH OF STAY IN Tb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Riverside Road</u>				d. STREET ADDRESS <u>Riverside Road</u>			
3. NAME OF DECEASED (Type or print) <u>Ralph</u> ^{First} <u>Alfred</u> ^{Middle} <u>Weschler</u> ^{Last}				4. DATE OF DEATH Month <u>12</u> - Day <u>28</u> - Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-3-1897</u>		9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auctioneer & Appraiser - - -</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Adam A. Weschler</u>				14. MOTHER'S MAIDEN NAME <u>Ellin E. McCormick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes - - -</u>		16. SOCIAL SECURITY NO. <u>578-03-4649</u>		17. INFORMANT <u>Lucile Edelen- See Item No. 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Cerebral cardiac failure</u> DUE TO (b) <u>Cerebral heart disease</u> stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>66</u> , to <u>12/28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>66</u> , and that death occurred at <u>5A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Gerard Rhurel</u>				22b. DATE SIGNED <u>12/28/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Gerard Rhurel</u>	
22d. ADDRESS <u>121 Cathedral St., Annapolis, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-31-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR <u>JAN 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

7221

1032 J. F. J.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16599

CERTIFICATE OF DEATH

16601

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 50		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 27 1/2 Hicks Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Dolly Ann WEST				4. DATE OF DEATH Month Day Year December 10, 1966			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH November 17, 1894		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Thomas Edmonds				14. MOTHER'S MAIDEN NAME Lucy Edmonds			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Samuel Golsen 1718 N. 28th Richmond		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinson's Disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.C. v. D. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7-3 yrs. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.A. uterus.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore	
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19__, to Dec 10, 1966 , that (I) (we) last saw the deceased alive on December 10, 1966 , and that death occurred at 10:10 AM from causes on and on the date stated above.							
22a. SIGNATURE Sam W. Gleser				22b. DATE SIGNED 12/10/66		22c. PHYSICIAN'S NAME (Type) Faye W. Alkew	
22d. ADDRESS 62 Cathedral St				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-15-66		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Ceme.		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR ADDRESS Mortome Dyett Fitt 1701 Laurens St.				25a. REC'D BY REGISTRAR DATE DEC 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File (pages) and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16600

16602

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital				d. STREET ADDRESS 7345 Furnace Branch Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLEMETINA Middle MARCEL Last WHITE				4. DATE OF DEATH Month December Day 1 Year 19 66			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1910	
9. AGE (In years lost birthday) yrs. 5		IF UNDER 1 YEAR Months 23 Days 23 Hours 0 Min 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME JAMES WHITE				14. MOTHER'S MAIDEN NAME CLEMENTINE GANTT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. —		17. INFORMANT CLEMENTINE WHITE Glen Burnie Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis (SDII) 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.				22. DATE SIGNED 12/1/66			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/3/66		23c. NAME OF CEMETERY OR CREMATORY St. John's Church		23d. LOCATION (City or Town) (County) (State) Maryland, Pasadena Md	
24. FUNERAL DIRECTOR Marshall H. Hayes 638 N. Lincoln St				25a. REC'D BY REGISTRAR DEC 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16601

16603

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	
3. NAME OF DECEASED (Type or print) First Ernest Middle Gilbert Last WILLIAMS		4. DATE OF DEATH Month December Day 28 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 24, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST U.S. GOV'T RET.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 66
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ERNEST G. WILLIAMS SR.		14. MOTHER'S MAIDEN NAME CORA GANTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. MARGARET F. WILLIAMS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prinimal steel - Wilson D 260X DUE TO Diabetes m Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diff femur fracture due to old abuse			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXX			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) was attended the deceased from Dec. 23 , 19 66 , to Dec. 28 , 19 66 , that (I) was last saw the deceased alive on Dec. 28 , 19 66 , and that death occurred at 5:30 PM M, from causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 12-29-66	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	12-31-1966	GLEN HAVEN CEM.	GLEN BURNIE PARK MD
24. FUNERAL DIRECTOR JOHN M. TAYLOR - SONS ANNAPOLIS MD		25a. REC'D BY REGISTRAR DATE JAN 3 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16602

CERTIFICATE OF DEATH

16604

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>02.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BY WATER RD</u>		d. STREET ADDRESS <u>BY WATER RD</u>	
3. NAME OF DECEASED (Type or print) <u>LAWRENCE E. WILLIAMS</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1897</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>02</u> Days <u>1</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VICE-PRES.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>JAMESTOWN N.Y.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEONARD J. WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>MAUDE LAWRENCE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war and dates of service) <u>YES 8/7/42/1/30/46</u>		16. SOCIAL SECURITY NO. <u>#2</u>	
17. INFORMANT <u>LOUISE H. WILLIAMS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma of breast</u> 170X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>12/2, 1966</u> to <u>12/3, 1966</u> , that (I) (we) last saw the deceased alive on <u>11/25, 1966</u> , and that death occurred at <u>9:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman, M.D.</u>		22b. DATE SIGNED <u>12/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St, Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L.</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON Va.</u>
24. FUNERAL DIRECTOR <u>John M. L. L. & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 7, 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16603

CERTIFICATE OF DEATH

16605

1. PLACE OF DEATH a. COUNTY <u>Crowsville State Hosp</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crowsville State Hosp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crowsville State Hosp</u>		d. STREET ADDRESS <u>218 N Durham St.</u>	
3. NAME OF DECEASED (Type or print) <u>Romes Wilson</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>24</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Gladys Wilson</u>		Address <u>2022 N. Hope St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Pneumonia, Hypostatic</u> DUE TO (b) <u>cerebral vascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3-5 days</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>8/14/39</u> , 19 <u> </u> , to <u>12/24/66</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12/24/66</u> , 19 <u> </u> , and that death occurred at <u>5 A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>L. Benedict M.D.</u>		22b. DATE SIGNED <u>12/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>Crowsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-29-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Putnam Ave</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn MD</u>
24. FUNERAL DIRECTOR <u>C. O. Wilson</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 29 1966</u>			

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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16604

CERTIFICATE OF DEATH

16606

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY in 1b 1 hr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel Gen. Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riviera Beach d. STREET ADDRESS 8585 Bay Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ISABEL HENRIETTA ZINDEL				4. DATE OF DEATH Month 12 Day 17 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1895	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York	
13. FATHER'S NAME Amedie Froustet				14. MOTHER'S MAIDEN NAME Carrie Seibert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 152-18-7628		17. INFORMANT Louis J. Zindel - same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH SUDDEN 10 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-1-1963, to 12-17-1966, that (I) (we) last saw the deceased alive on 12-12-1966, and that death occurred 10:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Arthur Lankford Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-17-66	
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD, JR., M.D.				22d. ADDRESS 2934 Mountain Rd. Pasadena, Md 21122			
23b. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. DATE THEREOF Dec. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City, town or county) (State) Ritchie Hgwy., A.A.Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce				ADDRESS 4001 Ritchie Hgwy., Baltimore		25a. REC'D BY REGISTRAR DEC 23 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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